continue an agreement we understand was made at the New York-Washington level, we believe Operation Salam should be tasked with finding funds to augment the UNICEF contribution.

-MSH, after graduating its present class of 48, should only train EPI technicians for areas were there is the necessary infrastructure to allow them to work within a pyramidal system where the technicians can train and supervise outreach health workers (at the BHW level) to immunize. The team suggests that this strategy be implemented in the provinces where the MOPH is developing provincial health services and in the Area Development Schemes.

-Given the tremendous costs of a large EPI program, the Team advises that the program be kept small, and be used to train Afghan authorities and institutionalize the process of implementating as cost-efficient an EPI delivery system as possible, with MSH's role being to assist the MOPH to incorporate all levels of trained PHC workers into support of a larger EPI effort.

-Primary support of the vertical components of the EPI program, in large part, should best be left to other organizations and donors.

-The Review Team agrees with the MSH plan to assist the MOPH and/or Area Development Committees set up small TB program(s), as these health delivery system(s) mature.

-The Team advises MSH not to get significantly involved in nation-wide malaria control efforts, except to assist Afghan authorities to plan for such efforts and to continue the support of the provision of treatment within a PHC system. AID malaria strategy documents may be useful.

III. TRAINING

A. Minimal Skills List

The SOW question concerns development of a minimal skills list to assist in standardization of categories of health workers being trained by many organizations.

We believe the continuing development of the minimal skills lists is useful and is moving towards the basis for competency-based certification.

With the addition of the MCH component in the basic and refresher BHW training, the MSH and MOPH training curricula appear to include the skills included in the current draft minimal skills lists.

-MSH and MOPH technical monitoring should be constructed to target these skills.

If the Rural Health Officer position is established and it is desired that he/she be considered a mid-level health worker, training should follow the minimal skills list for mid-level health workers. If the MOPH decides the list is too clinically oriented for the intended PHC supervisory emphasis (providing the supervisory and managerial link between the district/sub-district and the community health worker level), two options are available: the MOPH can push to broaden the minimal skills list, or it may lobby to establish a new category of health worker. The Team doesn't believe either of these options will be well received by the expanded group preparing the minimal skills list unless it is more completely aware of the intent of the MOPH in establishing the RHO position. The Team recommends that MSH work with the MOPH and the standard setting group to include the RHO under the evolving minimal skills list for mid-level health workers.

-To the extent possible, MCH and OB/GYN skills should be addressed in training and refresher courses for doctors and nurses.

B. MOPH Training Programs

By anyone's assessment, MCH care is the major health need in Afghanistan. The MOPH and MSH have begun slowly and carefully to train health workers to meet this need. With the inclusion of MCH training, the training programs which MSH assists seem to meet WHO standards with regard to curriculum and training. The question of quality might best be answered by competency-based certification exams.

-In order to secure more exposure to MCH in basic and refresher training for BHWs, the Review Team recommends that additional efforts be made to use training sites, possibly those of other PVO's, where there are active clinics for women and children.

-MSH support for the "Buddy Care" training courses of Mujahideen should continue in spite of the fact that any accurate evaluation of their worth appears impossible.

C. Proof of Need for Additional Training and/or Additional Facilities.

The Team believes that the level of war activities has ameliorated somewhat, allowing better planned and better distributed future additions of health resources by the donor community.

-The Team recommends that O/AID/Rep require that MSH (in the name of the entities it supports, including the AIG/MOPH and the Area Health Committees) and the large AID-supported health PVOs (IMC, FM, MCI and GAC) provide evidence that there is a need for additional workers and/or facilities before providing concurrence to fund such. Proof that need does exist should take into consideration the following: medical, political, topographic and geographic factors, population density, patient referral and supervision patterns/possibilities, and an inventory (listing) of other nearby existing health facilities and workers.

D. Short-Term Participant Training

The Review Team believes the concept of providing additional short-term participant training opportunities to selected individuals from the MOPH and Area Health Schemes is fully justified if for no other reason than helping to develop a critical mass of advocates for PHC concepts for post-war Afghanistan.

USAID and MSH should be firm in their insistence that all participant training involved be PHC in orientation, as it is likely that there will be enormous pressure to shoehorn in clinical opportunities. One exception to this would be that any type of MCH or OB-GYN opportunity for participant training of female candidates should be considered.

All short term training must include a focus on health care financing and planning for developing countries to ensure a basic understanding of financing and structuring health budgets for the optimum benefit of the people.

IV. MONITORING AND INFORMATION SYSTEMS

A. Use of the Monitoring System

Regarding logistics, MSH and the MOPH have set up a combined system which represents good checks and balances on the supply system.

Internal (cross-border, by non-Americans) monitoring visits have had a salutary effect on worker attendance as well as been useful for screening out from MSH support certain clinics and personnel for non-performance.

Monitoring efforts are being coupled with the efforts of the PVOs and the Area Health Schemes staff to get a combined picture of the fledgling health services system inside Afghanistan. The picture appears to be one of general cooperation and a desire to close the serious information gaps that exist concerning the true sense of facilities and staff in Afghanistan.

-MSH could make better use of the BHW interviews to get a clearer sense of health problems in Afghanistan and more information on the numbers of women and children being provided health services in the country.

B. Health and Management Information Systems (HIS/MIS)

MSH has developed a complex, and in all appearances, a quite thorough HIS/MIS. The Review Team did not have sufficient time to look at the adequacy of any of the more than 10 HIS/MIS systems used by MSH.

-MSH should spend less emphasis on the "computerization" of its own informational systems and begin placing more emphasis on transferring the appropriate information systems (or relevant components thereof) to the MOPH and to the Area Health Schemes.

-MSH should present a proposed annual schedule, beginning in the FY 1991 work plan period, for planned transfer of responsibility for appropriate MIS/HIS elements to the various Afghan health delivery systems.

V. INSTITUTIONALIZATION

A. Developing Afghanistan's Health Care System

It appears that the organizations and PVOs which the team contacted were providing cross-border health assistance which contributed to one (or more) of four health-service models. Three of these may be considered health system development models; i.e., efforts which attempt to develop health assistance within a context of national, area, or provincial systems, notwithstanding the fact that none of these systems are fully developed. The fourth model might be termed "anarchy", or providing direct (largely curative) services with little or no regard to the placement of such services within a larger health delivery system. This "anarchy" model is almost entirely supply driven. MSH has participated in all four models.

We believe the HSSP should continue to support development of the system at the national level, but should better clarify (communicate, coordinate) its objectives and intentions with the donor and PVO community.

-MSH effort in the Area Health Schemes likely represents the most fruitful opportunity for relatively rapid development of health system development, and therefore should be continued. The Team is particularly pleased to note the effort to support the Hazarajat Area Scheme.

The MOPH reportedly plans to name Provincial Health Officers in about 14 provinces. This will facilitate development of hierarchal health delivery systems. MSH does not plan to "adopt" a specific province for support, but will participate in planning with the MOPH, provide technical consultation in other areas (e.g., logistics, finance, manpower development), and be willing to mold its own supported training and supply activities to fit the various provincial plans.

-MSH support for training BHWs for deployment to areas which are not actively developing hierarchal services should be limited at the end of training of the current class of BHWs (eighth BHW training session now in progress), and at least eighty percent of all future BHW training should deploy graduates within a framework of a system, be it area or provincial, which will link the BHW to a supervisory, reporting and monitoring hierarchy.

-USAID should consider applying the same eighty percent formula mentioned above to its PVO grantees.

B. MSH and Ministry of Public Health Working Relationships

In our response, we have included MSH relationships with the PVOs.

MSH has worked so closely with the MOPH that some PVOs actually perceive the MOPH as being an MSH creation, clearly an undesirable perception. MSH is the largest US health-grantee and, as such, is a natural target and scapegoat for the PVOs. MSH might save itself a little grief from the PVOs and UN organizations by more strongly resisting the MOPH tendency to have MSH be its spokesman.

[But somewhat accurate!]

-MSH should continually communicate and coordinate with the PVOS to a greater extent. Communications should include clear identification of which initiatives are Afghan and which are MSH's.

-MSH should more actively pursue the recruitment of a senior Afghan coordinator than has been the case since the 1988 evaluation recommendation. USAID should require MSH to establish a deadline for this recruitment as part of an approved 1990 Work Plan.

[No! An "Uncle Ahmad"]

C. Transfer of Responsibility to Afghan Entities

-MSH should initiate a dialogue with the MOPH concerning the MOPH assuming responsibility for providing salaries. We believe, however, the likelihood is low for any Afghan government having resources for this purpose in the foreseeable future without outside assistance.

VI. FINANCIAL AND FISCAL SUSTAINABILITY

A. Review of the MSH-Developed "Sus-Plan"

The "Sus-Plan" developed by MSH is a useful guide to an APPROACH to working on sustainability for the Afghan health system. It is not a plan for sustainability and should not be viewed as such. The approach to sustainability in this document must be combined with the various monitoring systems outlined in IV A above to get a picture of the health system required for post-war Afghanistan. Only when staffing and facility guidelines have been agreed upon for such a system can an accurate picture be available of the costs of operating the system.

The Team differentiates between the terms "self-sustainability" and "sustainability". "Self-sustainability" refers to support of a post-war Afghan health system by resources, public and private, from Afghan sources only. The Team is unaware of a single country approximating Afghanistan's level of development which has a self-sustained health system anywhere near the WHO/UNICEF goal of "Health for all by the year 2000". The term "sustainability" herein refers to support of a post-war Afghan health system resulting from a combination of Afghan public and private resources AND total expected levels of donor support from all sources. Prior to 10 year's devastation by war, Afghanistan widely was included in the category of "poorest of the poor" nations, and attracted deserved donor assistance from multi-lateral, bilateral and private organizations. It is reasonable to assume (and we have done so), that assistance of this sort will again be provided to post-war Afghanistan for some prolonged period to help sustain an Afghan health system.

-Special operations research projects need to get underway to get a picture of the real costs associated with the delivery of health services required to treat the major diseases extant in Afghanistan and to find better ways to deliver critically needed preventive health services. Operations research concerning fee-for-service and fee-for-medication at all levels of the health system needs to begin now.

-The Team recommends that MSH and/or USAID bring to Peshawar experts in developing country health care financing so the MOPH and PVO community can be exposed to expert discussion in this important area.

-The Team recommends that USAID provide consultant assistance to its grantees (and other interested parties) in the uses of social-marketing as a method of cost-sharing between government and private sources.

B. Cost Cutting and Fee-for-Medication

The SOW question asks if there are ways to cut expenditures for drugs and equipment while maintaining quality services, and whether fee-for-medication can be introduced.

The question arises whether the SCA could be called upon to provide all pharmaceuticals and supplies to USAID grantees. Because of issues concerning source of procurement, FDA approval, and drug selection, and the comparatively slow fill-time for SCA pharmaceutical requests, and because of the advantages of not depending on a single medical logistic system (planned redundancy), the Review Team views this as a sub-optimal alternative at the present. Circumstances may dictate future consideration of this alternative.

One possibility for cost cutting would be to reduce the numbers/types of medications provided the BHWs.

The MSH staff in Peshawar is an exceptional mix of professionals, containing experts with long experience in a variety of developing countries (at war and in peace) and professionals with several years of recent first hand in-country (Afghanistan) experience, as familiar as any expatriates with the medical situation which exists and with the capabilities of the BHW. The Review Team strongly believes that the MSH Team is working on these issues on almost a daily basis, and is doing so in a responsible and professional manner.

-The Review Team recommends that the task of determining the appropriate make-up of medical supplies and equipment be left to the professional judgement of the MSH team with a minimum amount of outside second-guessing.

The Team doesn't believe that MSH or any PVO can make what amounts to a major policy decision concerning fee-for-medications alone. Each can contribute ideas, and we believe AID and others US agencies should solicit these thoughts. In the end, however, we believe this is a US government policy issue, and when a policy is established, those US-funded organizations involved in cross-border assistance will deal with it the best way they can.

C. MSH Expenditures against Program Priorities

A summary of the major tasks in the 1989 amended MSH Cooperative Agreement, and the estimated percent of planned program fund expenditures attributed to each task indicates to the Team that funds generally are being spent in correspondence to stated program priorities. Admittedly, a statement such as this (or even the reverse) cannot be presented

confidently because program priorities are not clearly stated, in either the AAM or the Cooperative Agreement.

The Team recommends the following:

-More funds and effort should be directed towards working with Afghan authorities to plan and begin implementation of sustainable health services in Afghanistan.

-When the time is appropriate and as signaled by the O/AID/REP, more emphasis should be placed on "institutionalization", the careful transfer of responsibility for systems and operations to Afghan authorities.

-MSH and USAID should develop an accounting system so that planned expenditures could be keyed to tasks called for in an amended Cooperative Agreement (in addition to the current system which keys expenditures only to administrative "Cost Centers"). This will be useful both to MSH and USAID in monitoring and evaluation of project activities.

-The program priorities of HSSP should be restated and more narrowly focussed to bring them up-to-date and make them clear and measurable. The restated, verifiable objectives should be made part of an amended Cooperative Agreement.

VII. COMMENTS BEYOND THE SCOPE OF WORK

The Review Team has some thoughts which were not included in the SOW, but which relate to the topic at hand:

1. Health grantees working in Afghanistan and the Committee for Medical Coordination (CMC).

The Review Team looked at the need for coordination among the various health organizations, grantees and others, working in Afghanistan and the role played by CMC in coordination.

When interviewed separately, CMC members were split on whether the continuation of CMC would make a difference. No one interviewed (excepting GAC) saw ACBAR as an effective vehicle for cross-border coordination. Some NGO's saw the WHO Program for Afghanistan as a coordinating mechanism, but thought it had drawbacks.

If CMC withers away, as it may (we have been told that UNICEF will discontinue funding and O/AID/Rep is considering the same), we can see the need for an organization very similar to CMC being "re-invented".

-If the majority of its members (particularly the five AID funded members) seriously want it to continue, the Team recommends that the O/AID/Rep consider offering CMC a matching grant to fund one half of the Committee's operations for 1990, the other half of the operation costs coming from membership dues. Estimated CMC operation costs are about $100,000 annually. We suggest one-half of this amount would be put up by the CMC members on a sliding scale. If the total from members were increased from $14,000 to $50,000, it would indicate sincerity on members' part to keep CMC viable. A focus on standardization and monitoring issues would be a condition required by O/AID/REP's provision of matching funds for CMC operation.

2. Assessment of Health Resources in Refugee Camps

If it is not being done, we believe someone should thoroughly inventory trained health personnel in the refugee camps to permit their inclusion in planning for post-war health care in Afghanistan. Similarly, some collection of known health assets existing in Kabul and other urban areas, as well as other known health assets, such as health workers trained by Iran and the USSR, would be helpful for planning purposes.

PROJECT REVIEW, AFGHANISTAN HEALTH SECTOR SUPPORT PROJECT (HSSP)

INTRODUCTION

The Health Sector Support Project was authorized on August 8, 1986 to: a) rapidly expand the availability of primary health care and first aid services inside Afghanistan; and b) assist in the development of the capability of the Alliance Health Committee (later the Ministry of Public Health of the Interim Government of Afghanistan) to plan and manage expanded health care services and participate in the eventual reconstruction of Afghanistan.

A Cooperative Agreement was executed with Management Sciences for Health (MSH), a not-for-profit public health consulting firm located in Boston, Massachusetts. MSH fielded a technical advisory team, headed by Dr. William Oldham, which established operations in Peshawar, Pakistan in January, 1987. In August, 1988 an external evaluation was laudatory of the MSH accomplishments to that date, and recommended, inter alia, that the project be continued with MSH support. At the time of AID's deliberative process concerned with the renewal, the Soviets had announced the schedule for the extraction of their forces from Afghanistan. AID approved continuation of the Project through December,1992, at significantly higher levels of funding (approximately $60,000,000 for the life-of-project). The higher funding levels were predicated in part to maintain flexibility of response capability in the event that headquarters for project operations moved into Afghanistan. AID Washington placed a requirement for a Project Review 18 months after approval of the AAM, and it is in response to that requirement that a team (the Review Team) conducted this review in January and February, 1990.

The MSH Cooperative Agreement was amended in February, 1989. The revised project purposes are:

1. Improve first aid and emergency services including medical and surgical care for war casualties, phasing down as the need subsides.

2. Expand general health care services for civilians including women and children as well as Mujahideen (Afghan "Freedom Fighters").

3. Enhance the capability of the Alliance Health Committee, other organized Afghan entities (private or public) and/or organized areas to plan, organize and manage expanded health care activities.

Six major tasks were assigned, including: development of area (regional) health systems; execution of primary health care

TABLE OF CONTENTS

TABLE OF CONTENTS.. i

LIST OF ACRONYMS AND ABBREVIATIONS..........................iii

EXECUTIVE SUMMARY.. iv

INTRODUCTION AND BACKGROUND................................ 1

THE REVIEW TEAM AND SCOPE OF WORK....................... 2

METHODOLOGY.. 2

ANSWERS TO QUESTIONS ASKED IN THE SCOPE OF WORK............ 4

I. PROGRAM MANAGEMENT.................................. 4

A. Merger of MSH and PVOs.............................. 4

II. HEALTH SERVICES DELIVERY............................ 5

A. Area Health Development Schemes..................... 6

B. Basic Health Workers; Midlevel Workers.............. 7

C. Competency-Based Certification of Health Workers............................... 9

D. Vertical Programs and EPI........................... 11

III. TRAINING.. 13

A. Minimal Skills List................................. 13

B. MOPH Training Programs.............................. 14

C. Proof of Need for Additional Training and/or Additional Facilities..................... 16

D. Short-Term Participant Training..................... 17

IV. MONITORING AND INFORMATION SYSTEMS.................. 18

A. Use of the Monitoring System........................ 18

B. Health and Management Information Systems.......... 20

services; development of Afghan health-training capability; work with Afghan groups to develop pilot activities designed to involve the population in supporting the costs of rural health care services; develop Afghan capability in medical supply and logistics; and, creation of Health Information and Management Information Systems (HIS/MIS).

THE REVIEW TEAM AND SCOPE OF WORK (SOW)

AID elected to constitute a four-person Review Team made of two outside consultants (including the team leader) provided through an Indefinite Quantity Contract with John Snow, Inc., and two experienced AID health officers, one the Director of the AID/W technical office (ANE/TR/HPH) which backstops health activities for Afghanistan, and the other the Health Development Officer from the staff of the O/AID/REP.

The Scope of Work was very specific as to the questions that were to be addressed by the Team (see Attachment A). The questions fell within the broad categories of Program Management, Health Services Delivery, Training, Institutionalization, and Financial and Fiscal Sustainability.

METHODOLOGY

The team (except the O/AID/REP member) met in Washington January 15,1990 and was briefed on the project, current health activities, and upon a recently completed evaluation of some PVOs working in cross-border health activities in Afghanistan. All members were provided any Mission- and AID/W-provided background documents which hadn't caught up with them prior to the Washington briefing.

After briefing by O/AID/REP Larry Crandall and his staff in Islamabad on Sunday, January 21, the entire Team moved to Peshawar, remaining there until through January 31. In Peshawar, the entire Team had initial meetings with the MSH staff and the Ministry of Public Health of the Afghan Interim Government, then separately or in groups met with many of the major UN organizations and PVOs involved in cross-border health assistance to gain their perspectives of the health situation in Afghanistan, a sense of their role in providing assistance, and the relationships of their efforts to MSH activities. Minutes were made of many of these meetings and were left with the Mission. (For a list of persons contacted, see Attachment B). Additionally, many sessions were spent with MSH staff in order to get the specific information useful in responding to the SOW. The Team met daily to coordinate activities, discuss issues, and later to review and react to draft portions of the report. On February 4, the Team made a verbal presentation to Mr. Crandall

and his staff, and left with them drafted portions of the report. The Team got immediate feedback to its verbal and written draft, and spent a day in Islamabad (a suddenly-declared National holiday) discussing that feedback. Having already delayed their departures (because a planned Team replacement for Jordan was unable to participate), Jordan and Zopf departed on February 5th and 6th. Shutt and Palmer returned to Peshawar, added and revised material, and met with the MSH Team on February 6th to get its reactions. The smaller Team then prepared the final draft report.

ANSWERS TO QUESTIONS ASKED IN THE SCOPE OF WORK (SOW)

I. PROGRAM MANAGEMENT

(A) Merger of MSH and PVOs

"The Team will review the health, financial and contractual issues involved in the merger of AID/REP's MSH and PVO activities under an HSSP umbrella. The Team will recommend if such a merger should be made, and if so how it should be accomplished - to include the structuring and timing of a possible merger."

The Review Team recommends against a merger of MSH and PVO activities under an HSSP umbrella. This recommendation is based on the following considerations:

(1) PVOs allow for and have provided innovation in the development and delivery of health care inside Afghanistan. If the PVOs were put under MSH, which has its defined scope (and given biases), it would tend to lock MSH and the PVOs into the same path.

(2) Keeping MSH and the PVOs separate provides competition, which may produce thoughts on and planning for better health care activities and systems. At the same time, it is important that MSH and the PVOs work hard to agree on and follow more standardized procedures.

(3) A merger as described could also set a bad precedent for any future Ministry of Health and its relationships with PVOs. It could indicate to the Ministry that PVOs are not a viable source of support for health care delivery -- something we do not want to communicate. In fact, the lack of independent PVOs may hamstring the Ministry; e.g., if at the present the Ministry does not agree with MSH on a given activity, it can seek assistance and guidance from a PVO, which it may not or could not do if the Ministry had to go through MSH to seek PVO assistance. By the same token, if the MOPH wished for some reason to disassociate itself from a particular PVO, the entire "MSH-PVO Coalition" might be dealt with as a single entity.

(4) Keeping the major US grantee contractually separate allows for flexibility. If a PVO or USAID wants to run a pilot activity at low cost and with alacrity, this might be done more rapidly via an independent PVO.

(5) An independent PVO can act as a multiplier of AID funds by attracting other funds -- e.g. from UN agencies or private donors. PVOs also have voting constituencies

which are important for generating long term interest in Afghanistan.

The only advantage to a contractual merger would be to ease AID/Rep's management burden, and even this benefit is questionable, given the very likely frictions between groups. Any administrative benefit would be greatly outweighed by the disadvantages.

II. HEALTH SERVICES DELIVERY

(A) Area Health Development Schemes

"Assess the regional health delivery systems in Shura-E-Nazar, South and West, and Hazarajat, and determine whether the design and implementation of these efforts is suitable to the needs, opportunities, and constraints, and judge the potential for integration of the different systems into an overall health care system for Afghanistan, including facilities presently operated by other than AID funded donors."

There is insufficient information available at this time to answer this question completely. In attempting an answer, however, what needs to be understood at the outset is that these Areas are quasi-civil administration areas put together out of many provinces under various commanders and under these administrations, a host of programs are being implemented in addition to health programs, including education, agriculture, road repair, reconstruction of wells and irrigation canals, and taxation.

Currently, there are three Area Health Schemes, Shura-e-Nazar, West and Southwest Area Development, and Hazara Area Development. It may be said that the remainder of the provinces, which in the main constitute the Pushtun area of the country, should come under the MOPH for health support and administration. There are political, as well as technical reasons, for USAID to support development of several models of health care delivery. Regarding the Area Health Schemes themselves, what is believed by some health experts is that these schemes may have a good chance of success because the regional health services administrators have an understanding of the needs of the people and the need to develop a sustainable health system. This appears true because these area administrators need to prove to the local population that they can deliver a service and that they have the best interests of the people in mind.

The potential for integration of these Area Health Schemes into a national health system could be quite good if the schemes follow a health pyramid with the primary focus on preventive

health care at the lowest outreach level, rather than a hospital-based curative program delivering free services which the areas (and Afghanistan) can ill afford to sustain. In contrast to some of the PVO health programs which seem to concentrate on hospital-based curative programs, these area schemes give every indication of a preventive health focus. It is encouraging to note that of the first two Provincial Health Officers appointed by the MOPH, one of these medical officers has been appointed to Kunduz Province which is part of the Shura-e-Nazar Scheme, and the second to Wardak, which is part of the Hazarajat Scheme. These appointments set in place the mechanism for direct links between important area programs and the MOPH. One can only hope that the regional administrators and the senior level officers of the MOPH will work together and learn from each other as more normal administration is established in Afghanistan. The Team recommends that MSH should try to stimulate the exchange of information between the MOPH and personnel of the Area Health Schemes in order that they may coordinate their plans for health systems development insofar as possible. It will also be critically important for PVOs that work in the provinces of the Area Health Schemes to ensure that what they are doing and the systems they are establishing complement the basic health systems being put in place by the various schemes. What one hopes for in the long run is an amalgamation of the best of each scheme into one national structure for health delivery.

Regarding facilities, closer cooperation between the groups that provide health assistance to Afghanistan is leading to better information sharing on the availability of health facilities (and personnel) in the country. O/AID/Rep commissioned the Committee for Medical Coordination (CMC) this past year to develop a map of health facility locations inside Afghanistan. WHO and ACBAR also have a strong interest in this subject, as have the PVOs who work in particular areas of the country. Working together, an initial map of facilities and personnel has been developed. It seems quite likely that a comprehensive map of facilities and personnel can be developed that can be updated systematically by continuous exchange of information among the Area Health Scheme administrators, staff of the MOPH, MSH, the PVOs and WHO, with CMC perhaps being given the task of keeping this map current and available. Once the map is better defined, plans for locating/relocating staff and facilities can take place on an informed basis and duplication can be kept to a minimum.

(B) Basic Health Workers; Midlevel Workers

> "It appears most PVO health programs are now beginning to design and implement refresher courses, in part to obtain a "mid-level" health worker (6-18 months of training). Are MSH short-term trained (3 to 4 months) BHWs no longer appropriate country wide or in some regions? Are there sufficient numbers of BHWs? What are the implications of the strategy to produce more mid-level health workers?"

In responding to this question, it should be kept clearly in mind that with the exception of vaccinators trained in some other programs, BHW training represents one of the few categories of health workers being trained with an orientation towards most elements of primary health care at the community level. It is true that the BHW performs more curative functions and has a greater variety of medications to offer than the community health worker found in most countries. This has been justified by MSH (and accepted by USAID) on the basis of the relative dearth of most kinds of curative resources in the rural areas of a country at war. The above notwithstanding, the BHW training has included heavy doses of community orientation and attention to the usual primary health care elements found in training courses in more placid countries.

One can argue that it is time to plan for a lesser emphasis upon curative treatment and for a pruning out of the pharmacopeia available to the BHW. MSH agrees, and has in fact been gradually reducing the medications available to the BHW, both in types and in numbers. Upon the presumption that whatever the structure of the health system after resolution of the current war, it will have at its base a community health worker, the BHW represents the only known trained cadre of which we are aware that is capable of filling that role. Accordingly, with the caveats which follow, the Team believes that the BHW is appropriate for all rural regions of the country:

1. MSH should attempt to reach agreement with PVOs that the BHW is the appropriate health worker for the base of the health pyramid;

2. Mechanisms must be greatly expanded for alleviating the near vacuum of MCH services within Afghanistan;

3. Continued and expanded efforts must be made to train and deploy female BHWs;

4. Experimentation with various hierarchal health delivery systems should continue in order to insure that BHWs are integral parts of a system, not independent providers.

5. A planned and scheduled reduction of curative emphasis and provision of medications should begin now.

6. MSH-supported MOPH refresher training should continue, with increasing attention to training slanted to the non-curative elements of primary health care, with particular emphasis on MCH care.

As to numbers of BHWs, MSH at the onset planned to train a cadre of 1700 BHWs. This was predicated on having one BHW for each 10,000 of the estimated post-war population, or one BHW for each 6000-7000 rural post-war population. At the beginning of 1990, there were 1467 BHW trained and deployed. The Review Team believes that 1500 - 1700 is a reasonable level of BHWs to maintain for the present. We don't know what the population of post-war Afghanistan will be, and doubt if anyone else can offer projections with any degree of assurance. This range, if maintained, we believe will come close to offering the rate of coverage (one BHW to 6000- 7000 post-war population) used in MSH's original projections, and demonstrably can be managed by both MOPH and MSH. The Ministry and MSH, we believe, should train now for maintenance within this range, largely training for losses from attrition and for deployment within developing area and provincial hierarchal health systems. (Of about 1700 trained, there have been about 220 lost to the system since the onset of the HSSP). The decreased teaching load required to produce large numbers of new BHWs may permit closing of some Pakistan-based training sites, increased quality in training new batches, and greater emphasis on retraining/refresher training.

In regards to the mid-level health worker training (as defined in terms of months of training), all or nearly all of such existing training is being done by others and seems to be clearly curative in orientation and deployment. We don't deny the need for such health workers within the health system of Afghanistan, nor do we argue against their continued production and deployment (although we would like to see deployment within a planned system of hierarchal care). The Team believes that the MOPH and MSH should lobby for inclusion of greater amounts of the preventive and promotive elements of PHC, including MCH care, in all training and orientation of mid-level health workers, and that as a condition of funding, USAID should insist that at least a working knowledge of the concepts of PHC should be emphasized in training courses provided by USAID-supported PVOs. If USAID is agreeable with the foregoing, managerially it would seem to make sense that O/AID/REP's backstopping of MSH and the PVOs (IMC, FM, MCI) engaged in these health activities be vested in the same technical backstopping officer.

MOPH and MSH are planning to embark on the training of a different category of mid-level health worker, the Rural Health Officer (RHO). Twenty-five male and 15 female RHOs are planned,

with placement within provincial health structures at sub-districts and districts to be determined by the MOPH on the basis of population, existing facilities and staff, need, security, etc. To the extent possible, selection of male candidates will be from existing BHWs. Eligibility requirements for other male and female candidates will be basically the same as that of the current BHW candidate: 9-12 years of education, demonstrated literacy, a willingness to serve and recommendation by the commander or civil authority to which he/she will be deployed. Recruitment will be from the area of planned deployment. Duties will include promotion, supervisory and monitoring responsibility of all PHC activities within his/her jurisdiction. The RHO will be managerially responsible for mobilizing even those who are primarily clinically oriented for such PHC activities as EPI, ORS, and MCH. Existing BHWs, who already have had PHC training, or new candidates who have not been taught a clinical orientation, will form this new cadre; existing clinically-oriented mid-level health workers will not be candidates. We are told that the concept for this RHO arose from the MOPH, and then MSH aided the Ministry in emphasizing the PHC orientation. Within the context of encouraging the MOPH's development of planned health systems with a distinct PHC emphasis, development of a category of health worker which will bridge the gap between the district and the base of the health pyramid seems feasible and needed. The Review Team recommends that:

1. MOPH and MSH further define the concept of the Rural Health Officer (RHO), certainly with full communication and consultation with the donor and PVO communities. We found ample evidence of resistance to this new category, due largely, we believe, to the fact that the bases for decision and selection are understood imperfectly. if at all, and are being viewed as being concocted and "imposed" by MSH.

2. If the job description is developed and agreed upon, then USAID should consider funding this category only with the caveat that 15 of the 40 requested positions be earmarked for females: up to 25 males might be approved for training - any number beyond that would have to be female.

(C) Competency-Based Certification of Health Workers

"Is it now the time and is it possible to standardize and provide competency-based certification to the different levels of health workers? What should be the HSSP role in this? How would these activities be implemented? Who would be the testing and certifying agent?"

In the main, the war emergency situation has shifted to one of care and maintenance. While continuing to provide for

casualties from the pockets of strife and land mines, MOPH, MSH and the PVOs providing health care are beginning refresher courses and reprogramming training courses to upgrade workers and, in some cases, add MCH components. While there has been a general agreement on the need for standardization and certification, the emergency nature of early assistance delayed the process. **The Team believes it is timely to standardize levels of health care workers and provide competency based certification**, because:

1. The health care workers would have their chances of employment in planned health systems enhanced.

2. Standardization and competency-based certification would facilitate rational MOPH health planning. It would give it a head start and, possibly, ease the patronage issue somewhat.

3. MSH and PVOs agree on the need and advantages. It is especially timely considering the reprogramming and restructuring of training programs currently underway.

4. Last, certainly not least, the Afghan people will be better served by the placement of competency-tested and certified health workers.

The HSSP role in this has been ongoing. As a member organization of CMC, MSH personnel have participated from the beginning in the lengthy process of standardizing minimal health skills. **MSH needs to play a role in facilitating the MOPH's participation in, and both MSH and MOPH need to work with CMC and WHO on, the restructuring of the minimal skills lists for health workers.** The bottom line should be coordinated efforts, with all groups working with the MOPH.

WHO has begun implementation of the certification process. The MOPH should play a role in this process, along with the CMC (including MSH) and WHO. The MOPH would like to be the testing and certifying agent. WHO is already at work on coordinating a competency evaluation exam, and many organizations feel that a WHO imprimatur will be recognized and useful whatever the post war situation brings.

The Review Team recommends a compromise solution to the question of who should coordinate the standardization of categories of health workers and certifying the results of competency-based tests: after agreeing to the standards, testing would result in two certificates being given, one from the Ministry and one from WHO.

(D) Vertical Programs and EPI

"Should the HSSP, at this time, operate "vertical" (sole purpose) programs? Review recent MSH and MOPH experience with the EPI program. Are vertical programs feasible, effectual and cost effective? Is there now sufficient infrastructure and population concentrations in Afghanistan to warrant vertical programs? What vertical programs (e.g., malaria, TB, ARI) should be attempted, if any?"

Vertical health programs require a separate cadre and expensive support (offices, transport, etc.). Vertical programs will be very expensive for any future Afghan government, even with generous donor support provided over the long term -- which, may be slow in coming.

The Review Team recognizes the past justification for beginning EPI solely as a vertical program in the "MOPH-controlled" areas, given political factors (e.g., commanders choosing candidates for EPI technician training), and the fact that there existed only rudimentary supervisory/referral systems in the targeted districts in the selected provinces (Ghazni, Logar and Konar). The Team is concerned that the MOPH may now want to adopt an expensive national vertical program even though MSH advises the MOPH to eventually have the required minimum of vertical elements of EPI strongly supported by a PHC system operating through a clinic-based, outreach strategy. The Team recommends that MSH attempt to influence Afghan authorities away from conceptualizing a predominantly vertical EPI program.

MSH presently has 48 EPI technicians, giving immunizations and infrequently working out of fixed clinics. The system appears to be informal, for the most part vertical and following a campaign strategy. At present (February, 1990), 48 additional EPI technicians are in training and will follow the same mode of operation. The success of this strategy on coverage rates is unknown; the expense of the strategy can be calculated and looks expensive, taking up approximately 10 percent of the total program budget (MSH FY 1990 projections).

UNICEF has been supplying all vaccines to the program; however, MSH was told in Peshawar that its EPI budget will be almost halved. The HSSP has been requested to purchase the majority of the vaccines to be used. MSH has been requested to provide vaccines costing $500,000, with UNICEF supplying vaccines worth $200,000. If MSH were to do this, it estimates it would need to increase the vaccine budget by 20 percent to continue in FY 91. In a follow-up, the Review Team was told by UNICEF in Islamabad that there must be a misunderstanding, as UNICEF does have sufficient funds for vaccines. MSH and USAID must follow up on this matter. The Review Team recommends against MSH funding

V. INSTITUTIONALIZATION.............................. 21

A. Developing Afghanistan's Health Care System..... 21

B. MSH and Ministry of Public Health
Working Relationships.......................... 25

C. Transfer of Responsibility to Afghan Entities... 25

VI. FINANCIAL AND FISCAL SUSTAINABILITY................ 26

A. Review of the MSH-Developed "Sus-Plan".......... 26

B. Cost Cutting and Fee-for-Medication............. 27

C. MSH Expenditures against Program Priorities..... 31

COMMENTS BEYOND THE SCOPE OF WORK...................... 33

ATTACHMENTS

ATTACHMENT A: Scope of Work

ATTACHMENT B: Persons Contacted

ATTACHMENT C: Partial List of Documents Reviewed

ATTACHMENT D: Review Team's Schedule

of vaccines for its EPI support activities until the matter of UNICEF's ability to provide them is settled. In the event UNICEF is not prepared to continue an agreement we understand was made at the New York-Washington level, we believe Operation Salam should be tasked with finding funds to augment the UNICEF contribution.

The Review Team believes that MSH, after graduating its present class of 48, should only train EPI technicians for areas were there is the necessary infrastructure to allow them to work within a pyramidal system where the technicians can train and supervise outreach health workers (at the BHW level) to immunize. The Team suggests that this strategy be implemented in the provinces where the MOPH is developing provincial health services (e.g., Wardak), and in the Area Health Schemes.

Given the tremendous costs of a large EPI program, the Team advises that the program be kept small, and be used to train Afghan authorities and institutionalize the process of implementating as cost-efficient an EPI delivery system as possible, with MSH's primary role being to assist the MOPH to incorporate all levels of trained PHC workers into support of a larger EPI effort. The Team believes that support for the EPI program, in large part, best be left to other organizations and donors. We hope that UNICEF, which has spearheaded EPI world-wide, will be able to increase its EPI funding for Afghanistan.

The Review Team agrees with the MSH plan to assist the MOPH and/or Area Development Committees set up small TB program(s), as these health delivery system(s) mature.

The Team advises MSH not to get significantly involved in nation-wide malaria control efforts, except to assist Afghan authorities to plan for such efforts and to continue the support of the provision of treatment within a PHC system. The Team recognizes that malaria is a significant problem in some areas of the country; however, a national malaria control program would necessitate an expensive vertical effort for which another donor should be approached. There are important roles that the PHC system should play in carefully-considered malaria control programs. The Agency for International Development has devoted much time and effort in producing strategies for such assistance for both global and Bureau levels. We believe these strategy documents will be helpful in conceptualizing MSH support.

III. TRAINING

(A) Minimal Skills List

"Is the CMC/WHO minimum skills list adequate? Should MSH and MOPH follow this list in their training and technical monitoring?"

A review of the CMC/WHO minimal skills list with the appropriate references to the ACBAR guidelines, coupled with information on the numbers and skills of the health workers trained to date, highlights the incredible accomplishments of the MOPH, MSH and the PVOs. A large number of health care workers with many skills have been trained to help meet the needs of the Mujahideen and the civilian population. With the deplorable health conditions in Afghanistan, these skills will continue to be needed. The continuing development of the minimal skills lists is useful and is moving towards the basis for competency-based certification.

As a member of CMC, MSH had a role in preparing the minimum skills list. If MSH-supported MOPH trained health workers seek competency-based certification (assuming standardization and certification are implemented), it would then certainly be advisable for their training and technical monitoring to follow the guidelines included in the lists. With the addition of the MCH component in the basic and refresher BHW training, the MSH and MOPH training curricula appear to include the skills included in the current draft minimal skills lists. The Team recommends that technical monitoring be constructed to target these skills.

MOPH training for a Rural Health Officer is in the planning stages with curriculum and tasks still being defined. In addition to mid-level skills, he/she will be given managerial and administrative training. If the Rural Health Officer position is established and it is desired that he/she be considered a mid-level health worker, his/her training should follow the minimal skills list for mid-level health workers. If, on the other hand, the MOPH decides that the minimal skills list is too clinically oriented for the intended PHC supervisory emphasis (providing the supervisory and managerial link between the district/sub-district and the community health worker level), at least two options are available: the MOPH can push to broaden the minimal skills list to more completely capture the managerial/supervisory tasks, or it may lobby to establish a new category of health worker which is more systems oriented and less clinically oriented. The Team doesn't believe either of these options will be well received by the expanded group preparing the minimal skills list unless it is more completely aware of the intent of the MOPH in establishing the RHO position. If the position is to be established, the Review Team recommends that MSH work with the MOPH and the

standard setting group to include the RHO under the evolving minimal skills list for mid-level health workers.

It is not reasonable to standardize the refresher courses for clinical doctors and nurses provided in the MOPH training center and Peshawar hospitals. A clinical practicum approach is used by necessity and attention is given to the doctors' and nurses' stated needs and objectives, although a tutorial in the principles of PHC is provided. While there is no minimal skills list for doctors, there is an MCH list that is recognized as being only an ideal. The Review Team recommends that to the extent possible, MCH and OB/GYN skills should be addressed in training and refresher courses for doctors and nurses.

(B) MOPH Training Programs

> "Judge the quality of the MSH-assisted MOPH 3-month BHW training program and the 12-day refresher course training vis-a-vis World Health Organization standards; and judge MSH-supported MOPH training programs vis-a- vis the present needs in Afghanistan."

One criticism often heard concerning the BHW in the field is "How can the BHW be a basic health worker with no MCH training?" In the past, the lack of an MCH component was a deficiency in the 3-month training program and the 12-day refresher course, and precluded it from meeting WHO or any PHC standards. Following the August 1988 evaluation recommendations and the evolution from war emergency to care and maintenance, an MCH component has been included in the BHW curriculum. As BHWs come in for supplies, MOPH and MSH give them a 12-day refresher course which includes MCH. The plan is that each BHW will receive this refresher at least annually. To date, approximately 500 BHWs have been through the course once. The refresher course has been shifted to a training site where it is possible to see women and children. In order to secure more exposure to MCH in basic and refresher training for BHWs, the Review Team recommends that additional efforts be made to use training sites, possibly those of other PVO's, where there are active clinics for women and children.

With the inclusion of MCH training, the training programs which MSH assists seem to meet WHO standards with regard to curriculum and training. The question of quality might best be answered by competency-based certification exams.

Afghanistan's needs are vast. The life expectancy, infant and maternal mortality rates, and Physical Quality of Life Index (PQLI) were among the worst in the world pre-war, they remain so at present and are likely to continue due to a myriad of multi-sectoral problems. Minimal resources, uncertain political future

and rigid cultural and geographic restrictions should be kept in mind during all training and planning sessions.

The MOPH training programs have turned out targeted numbers of BHWs and increasingly have deployed graduates to respond to geographic need rather than to Tanzeem (political party) pressures. MSH argues that while performance is not perfect, the BHWs still save lives in casualty care and in such common diseases as ARI, diarrhea and dehydration, and malaria. The provision of additional MCH and Dai training capability will make this argument more convincing.

Health resources rarely "trickle down" and Afghanistan's rural health system needs peripheral or village level workers. MOPH training programs for BHWs are aiming at this need; ideally, the Ministry (with MSH technical assistance) will continue to decrease the number of drugs provided (see Part VI B below), increase the MCH component and train with standardization of skills fitting into a linked health system.

MSH is also supporting a two-day "Buddy Care" first-aid training program for the Ministry. The course is given to the Mujahideen at relatively low cost. To date (January 1990), training has been provided for over 29,000 Mujahideen. The fighting goes on and land mines produce casualties among the military and civilian populations. The basic first-aid skills (controlling bleeding, immobilization of fractures, handling and transportation of casualties, etc.) of these graduates are credited by field commanders with saving many lives. These are skills useful at any time, the training requires no planning for sustainability in post-war Afghanistan, and the trainers and centers already set up can be used. Because of the foregoing reasons, the Review Team recommends that MSH support for the "Buddy Care" training courses of Mujahideen continue in spite of the fact that any accurate evaluation of their worth appears impossible.

The new programs for training x-ray and laboratory technicians (who will be trained using other PVO training centers) is in response to specific placement needs in MSH-supported clinical facilities in Afghanistan which can justify their use. The quality of the training provided by these other training groups has been thoroughly tested by their graduates performing satisfactorily in clinical facilities under conditions similar to those faced by MSH-supported clinics.

For a discussion of the training of immunization technicians, see Part II D above.

By anyone's assessment, MCH care is the major health need in Afghanistan. The MOPH and MSH have begun slowly and carefully to train health workers to meet this need. Upgrading of BHWs in MCH

and their ability to extend some training to Dais is an important step. The Dai training program being set up in Takhar as part of an Area Health Scheme will meet a felt need and serve as a valuable pilot activity.

(C) Proof of Need for Additional Training and/or Facilities

"Should O/AID/Rep require MOPH and MSH (or Area Health Schemes) to provide proof (spatial maps of existing health facilities, estimated population densities, etc.) before allowing training of additional health personnel and/or the establishment of new health facilities?"

The Review Team believes that a response to this question should indicate consistency on the part of AID. Accordingly, the response will be directed at all USAID grantees, including PVOs.

The Team believes that under the present circumstances, when there are many questions concerning both the necessity for more health workers and the apparent maldistribution of existing health workers at all levels ("guestimates" range up to 7,000 health workers outside the PDPA-controlled areas), there is a clear need to carefully plan and coordinate the addition of new workers and facilities. Databases exist at the MOPH, WHO and CMC to facilitate planning. Coordination among implementing agencies is taking place, but must be significantly improved. A requirement such as suggested below will facilitate this coordination.

The Review Team recommends that O/AID/Rep require that MSH (in the name of the entities it supports, including the MOPH and the Area Health Schemes) and the large AID-supported health PVOs (IMC, FM, MCI and GAC) provide evidence that there is a need for additional workers and/or facilities before providing concurrence to fund such. The Team further recommends that a mutually agreed upon (by the grantor/grantees) protocol be made part of the upcoming cooperative agreements.

The suggested wording of the protocol to be submitted to the AID/Rep grantees is as follows:

"No new health workers will be trained for, nor any new health facilities be set up inside Afghanistan using AID funds, until the O/AID/Rep provides its concurrence to the criteria which shall be used for planning placement of personnel or facilities. The criteria should be part of the annual work plan or similar document. Concurrence will be based upon AID's agreement that by following the criteria, the grantee will have produced evidence that a new health worker(s) and/or health facility(ies) is(are) needed in respective geographical areas. Proof that need does exist should take into consideration, as appropriate, the

following: medical, political, topographic and geographic factors, population density, patient referral and supervision patterns/possibilities, and an inventory (listing) of other nearby existing health facilities and workers."

The Team recommends that each O/AID/Rep grantee, including MSH, be subject to the same protocol.

(D) Short-Term Participant Training

"Should MSH send more government health professionals overseas for short-term training, such as it did with the MOPH Director of the Institute of Training?"

MSH funded both the Director and a professional the MSH training staff to attend the Boston University summer course on health in the developing world. Since his return, the Director has been an unabashed and vocal supporter of the concepts of primary health care from a position of some influence (the MOPH) and in a position of line authority. It is his, MSH's and the Review Team's opinion that his commitment and orientation towards PHC have had enormous sway upon the acceptance of PHC within the MOPH, a prodigious feat given the strong clinical orientation of the large majority of the other MOPH members. The young professional in the MSH training unit also is now cognizant of the world-wide approach to PHC and helps to infuse this in the MSH training programs.

The Review Team believes the concept of providing additional short-term participant training opportunities to selected individuals from the MOPH and Area Health Schemes is fully justified if for no other reason than helping to develop a critical mass of advocates for PHC concepts for post-war Afghanistan. Some trainees may assume pivotal roles in the post-war health hierarchy immediately; others may initially be in lesser supporting roles but be likely to assume more important roles eventually.

The Team believes that training of this type can have enormous impact in the shaping of the future Afghan health system, and encourages USAID and MOPH to consider providing more training opportunities of this sort. More direct MSH/USAID involvement in the selection process may be necessary than is true in more conventional participant training programs in order to insure cross-party and cross-ethnic representation in the selection process. Because of resource constraints, USAID and MSH should be firm in their insistence that all participant training involved be PHC in orientation, as it is likely that there will be enormous pressure to shoehorn in clinical opportunities. One exception to this would be that any type of

MCH or OB-GYN opportunity for participant training of female candidates should be considered.

All short term training must include a focus on health care financing and planning for developing countries to ensure a basic understanding of financing and structuring health budgets for the optimum benefit of the people.

IV. MONITORING AND THE MANAGEMENT AND HEALTH INFORMATION SYSTEMS (MIS/HIS)

(A) Use of the Monitoring System

"Can more systematic use be made of the existing monitoring system by MSH, MOPH and O/AID/Rep to provide empirical bases for technical and logistical funding decisions?"

Regarding logistics, MSH and the MOPH have set up a combined system which represents good checks and balances on the supply system. In the first instance the BHW or clinic personnel are interviewed jointly by MSH and the MOPH when they come to Peshawar for resupply of commodities. There is a duplicate record system with a feedback loop from the supply issuing point at the border depot, with an MSH employee working in the depot to ensure that the right goods are given to the right person and to observe that there is evidence the commodities are indeed being prepared to be shipped to the province. There is also a feedback loop from the depot with each shipment to keep a running check on the cost of shipping goods into each location. This allows MSH to continuously update the shipping cost data base to ensure that the health personnel are given the correct amount to cover shipment. The systematic use of this information seems to be well designed and the information well utilized.

The technical side of the equation is more complicated, yet most assuredly affects the overall logistics picture. There are several aspects to technical monitoring:

The first involves interviews of BHWs and clinic personnel when they return to Peshawar. MSH has systematically conducted these interviews over the past two years to try to get a more accurate picture of health needs and treatment patterns in the country which could be used both to update the training course as well as confirm (or call into question) the drug supply lists for various categories of workers. A newer element in this monitoring process has been the addition of a twelve day refresher course for BHWs. This course has been based on feedback from the BHW interviews and is updated as more information is gathered from the participants.

The second involves analysis of the Green Books. While the Green Books have instilled the concept of record keeping, the task has been less successful in inculcating "truth in reporting." Some of the BHWs keep a running record which is most useful for getting a health picture of the area and treatment modalities. Other BHWs have been sloppy and have filled in the book willy-nilly to justify supplies rather than to keep an accurate record in a systematic manner. MSH has decided to discontinue coding the Green Books into the computer data base until a way can be found to improve the data collection process. O/AID/Rep has also contracted with CMC to conduct a review of the PVO Green Books. For the present, qualified medical personnel can screen the Green Book during a BHW interview, get a sense of the quality of the data, and with well kept books, get a good picture of local health conditions. This in itself justifies in some sense continuation of the Green Books, with a longer term effort focussed on improvement of record keeping at all levels.

The third monitoring element involves the monitoring teams hired by MSH. To date, these have made 130 trips inside Afghanistan to ensure that personnel are in place and that commodities are being used to treat the local population. These internal monitoring visits have had a salutary affect on worker attendance as well as been useful for screening out certain clinics and personnel for non-performance. The monitors themselves consist of two person-teams, one from MSH, and one who knows local conditions hired from the ranks of the Mujahideen. Effort is made to hire the disabled and those interested in ensuring that health care is available for their people and that funds that have been made available for Afghanistan are being properly used inside Afghanistan. With time, the best of the monitors have been put on full-time status. MSH hopes that eventually a corps group of monitors will form the nucleus for an MOPH monitoring unit within Afghanistan.

Another monitoring element relates to the fact that the Clinic Division of the Basic Health Services Department of the MOPH has issued an order to clinic personnel inside Afghanistan to come to Peshawar for interviews by a medical sub-committee of the MOPH. The interviews will lead to certification of qualifications of the clinic personnel. This process should lead to the weeding out of unqualified personnel who may have been put in place in the earlier days of the war.

These monitoring efforts are being coupled with the efforts of the PVOs and the Area Health Scheme staff to get a combined picture of the fledgling health services system inside Afghanistan. The picture appears to be one of general cooperation and a desire to close the serious information gaps that exist concerning the true sense of facilities and staff in Afghanistan.

On the negative side, there does not appear to have been a rapid enough effort to refine/redefine the various medical kits issued to health personnel. There is strong disagreement within the PVO community, including MSH, regarding what constitutes the appropriate level and mix of drugs for various workers. Based on more thorough analyses of the results of their and others' monitoring systems, the Review Team believes that MSH must continue to review the contents of the medical kits to help resolve this vexing problem (see also discussion in Part VI B below).

There is also the belief that MSH could make better use of the BHW interviews to get a clearer sense of health problems in Afghanistan and more information on the numbers of women and children being provided health services in the country. This information seems to be collected and noted during initial supply interviews, but the information does not appear to get integrated into the retraining program.

Finally, and perhaps as important as any finding, the Review Team believes strongly that if the USG is serious about monitoring and wants to maintain credibility within the community supporting the provision of health services (and within a much broader community as well), then the USG must lift the ban on travel inside Afghanistan by US citizens (including USAID Direct-Hire personnel) working with USAID-funded grantees. This Review Team belief was endorsed virtually unanimously by every USAID employee, grantee, PVO and UN official contacted.

In a similar vein, the apparent reluctance of the AIG to move its operational base from Peshawar and into Afghanistan is a constraining factor in the delivery of health services.

(B) Health and Management Information Systems

> "Assess progress on the development of the health information and management information systems (HIS/MIS). Are the data these systems are designed to obtain appropriate for program monitoring, development, implementation and any necessary redesign?"

MSH has developed a complex, and in all appearances, a quite thorough HIS/MIS. Although some information-gathering tools need refinement such as the Green Book (designed by SCA) and the field monitoring reporting, appropriate information is available to MSH (although not always used, see Part IV A above) to make implementation and design decisions. Noteworthy recent improvements have been made in the finance MIS (detailed "cost center" readout capabilities) and the development of a computerized drug inventory control package (DICP) which quickly

proved its usefulness by pointing out an oversupply (temporary) of certain pharmaceuticals.

The Review Team did not have sufficient time to look at the adequacy of any of the more than 10 HIS/MIS systems used by MSH. **The Review Team recommends that MSH should spend less emphasis on the "computerization" of its own informational systems and begin placing more emphasis on transferring the appropriate information systems (or relevant components thereof) to the MOPH and to the Area Health Schemes.** In saying this, we note MSH does recognize the need to transfer HIS/MIS systems to the Afghan authorities, and some progress has been made in this area (i.e. a manual warehouse-accounting system has been introduced to the Supervisory Council of the North's Area Health Scheme.)

The Review Team **recommends that MSH should present a proposed annual schedule, beginning in the FY 1991 work plan period, for planned transfer of responsibility for appropriate MIS/HIS elements to the various Afghan health delivery systems.**

V. INSTITUTIONALIZATION

(A) Developing Afghanistan's Health Care System

> "What has been MSH's role vis-a-vis the PVOs and other donors in developing Afghanistan's health care system and "strengthening the capacity" of the AIG/MOPH to manage an expanded pyramid of health services inside Afghanistan? Should it maintain or alter that role?"

Although not all will agree, it appears to the Review Team that the organizations and PVOs which the team contacted were providing cross-border health assistance which contributed to one (or more) of four health-service models. Three of these may be considered health system development models; i.e., efforts which attempt to develop health assistance within a context of national, area, or provincial systems, notwithstanding the fact that none of these systems are fully developed. The fourth model might be termed "anarchy", or providing direct (largely curative) services with little or no regard to the placement of such services within a larger health delivery system. This "anarchy" model is almost entirely supply driven. MSH has participated in all four models.

-National Level

Perhaps more than any other organization or PVO, MSH has attempted to collaborate with an official or at least semi-official Afghan health/medical organization in its earlier relief and later more traditional developmental health efforts. As was the case of every other donor-sponsored entity and/or

LIST OF ACRONYMS AND ABBREVIATIONS

AAM	Activity Approval Memorandum
ACBAR	Agency Coordinating Body for Afghan Relief
AHC	Alliance Health Committee
AID	Agency for International Development
AID/W	Agency for International Development, Washington, D.C.
AIG	Afghan Interim Government
AMI	Aide Medicale International
ANE	Asia and Near East Bureau, AID/W
ARI	Acute Respiratory Infections
AVICEN	Afghanistan Vaccination and Immunization Center
CMC	Coordination of Medical Committees
EEC	European Community Commission
EPI	Expanded Program of Immunization
FM	Freedom Medicine
GAC	German Afghanistan Committee
HIS	Health Information System
HPN	Health, Population and Nutrition Branch, ANE
IMC	International Medical Corps
MCH	Maternal and Child Health
MCI	Mercy Corps International
MDM	Medecins du Monde
MIS	Management Information System
MOPH	Ministry of Public Health
MRCA	Medical Refresher Course for Afghans
MSF	Medecins Sans Frontieres
MSH	Management Sciences for Health
MTA	Medical Training for Afghans
NGO	Non-Govenmental Organization
O/AID/REP	Office of the AID Representive to Afghanistan
OB/GYN	Obstetrics and Gynecology
ORS	Oral Rehydration Solution
PVO	Private Voluntary Organization
SOW	Scope of Work
SCA	Swedish Committee for Afghanistan
TB	Tuberculosis
UN	United Nations
UNICEF	United Nations Children's Fund
UNOCA	United Nations Offices for Coordination for Afghanistan
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

PVO, MSH initially had to deal with the medical sub-committees of the many tanzeems or political parties. MSH encouraged the coalescence of 4 (later 5) of these party sub-committees into the Alliance Health Committee (AHC), and to the extent possible, sought agreement of ("clearance" or "no objection") MSH activities from the AHC to have the best possible imprimatur from whatever Afghan government existed in Peshawar. By the same token, since the conversion of the AHC to the MOPH of the Afghan Interim Government (AIG), MSH has worked so closely with the MOPH that some PVOs actually perceive the MOPH as being an MSH creation. Some PVOs and UN organizations are led to this conclusion at times, for example, because when the PVO/UN organization asks the MOPH to attend a meeting, the MOPH in turn asks its colleagues in MSH to attend (MSH usually has been asked to attend in its own right) and report back to it the substance of the meeting. The PVO/UN, then, has asked for MOPH attendance and has gotten MSH "representation", and interprets this as MSH blocking access to the MOPH (even in cases where MSH had urged the MOPH to attend).

Detractors would say that the MOPH has concentrated its efforts to provide services to the six or more near-border provinces. While this perception may have had validity, the MOPH has expanded its horizons and is developing an organizational structure (albeit in Peshawar) which looks more like the structure of health ministries in many other developing countries. MSH strongly has influenced this expansion of vision and shaping of the MOPH to have a distinct strong rural, preventive and PHC flavor. Of the MOPH's planned 16 Departments, 11 are staffed. Of the 11, MSH supports 8 involved fairly directly with PHC and rural health delivery.

The point of the foregoing is that MSH has tried very hard to incorporate recognized (official) Afghan health/medical authority in delivery of a large part of the MSH-supported health package. This, the Review Team believes, is a fundamental precept of institution building in the accepted USAID context. There are some who quite logically may argue that the AIG MOPH will not emerge as the post-war entity, so why bother? MSH essentially has said, "It's what there is and we'll go with it". Since this latter attitude seems to represent a sanctioned US position, it seems reasonable to the Review Team. We believe the HSSP should continue to support development of the system at the national level, but should better clarify (communicate, coordinate) its objectives and intentions with the donor and PVO community.

-Area Level

For discussion of the Area Health Schemes, please see part II A above. MSH has supported development of these delivery systems somewhat independently of the AHC and the MOPH,

apparently somewhat to the consternation of the MOPH. Inasmuch as these schemes for system development contain large numbers of rural population, are situated in decentralized areas of civil authority (at least by current Afghan standards), and permit attempts at development of a full pyramid of the health delivery system, MSH views these as targets of opportunity for testing health delivery models under civil authority. The establishment of the area health scheme in the North certainly, and to a somewhat lesser extent in the other two areas, came after strong in-country requests for support to health delivery. From what we were told about the administrative capabilities (military and civil) of Commander Masood, we believe that most health assets of PVOs, other donors and providers will be encompassed maximally into a system. The other two schemes are not as well developed as in the North, and probably are at higher risk because of a lesser degree of established civil authority and because of geographic considerations. In spite of the risks, it is the opinion of the Review Team that MSH effort in the Area Health Schemes likely represents the most fruitful opportunity for relatively rapid development of health system development, and therefore should be continued. The Review Team is particularly pleased to note the effort to support the Hazarajat Area Scheme.

-Province Level

The concept of starting to organize provincial health services at provincial level is not a new concept, but only in recent months has the MOPH seemed to galvanize action by its appointment of a Provincial Health Officer (PHO) in Wardak Province. The officer has travelled from Peshawar to Wardak, established communication with most of the various power authorities, and personally conducted a health facilities survey in three of the seven districts, producing a useful report of the latter. (The completed districts were populated primarily by Sunni Muslims). The survey showed, inter alia, that two PVOs were supporting clinics of similar capability too close to one another. The Health Officer returned to Peshawar and reportedly met with each of the PVOs to attempt to get one to move its clinic to a location which will provide more equitable distribution of services (with what results we don't know). He also reportedly has returned to Wardak and is completing the facilities survey in the four districts populated primarily by Shiite Muslims. We heard that at least two PVOs (Medecin du Monde and Freedom Medicine) are interested in working with the MOPH in developing this provincial concept.

The MOPH reportedly plans to name Provincial Health Officers in about 14 provinces. MSH has been told that PHOs have been named for Kunduz and Ghazni provinces, and will be named soon for Kunar, Logar, Bamyan and, perhaps, Herat

provinces. These PHOs are physicians reportedly coming from the province to which they are/will be assigned.

MSH has encouraged the MOPH in its efforts to plan for provincial development, and has consulted with the Ministry in the latter's planning. MSH feels that the phasing of the Ministry's planning is not ideal, but that the Ministry has made a good start. MSH does not plan to "adopt" a specific province for support, but will participate in planning with the MOPH, provide technical consultation in other areas (e.g., logistics, finance, manpower development), and be willing to mold its own supported training and supply activities to fit the various provincial plans.

- "Anarchy" Development

When USAID initially funded MSH and cross-border health activities, the operative mind-set quite understandably was to mount a disaster relief effort, and to get as many health resources into Afghanistan as was possible within a short period of time. Many organizations, MSH included, did a superb job in doing just that, unquestionably with good effect. As the situation stabilized (again, by Afghan standards), MSH and other organizations began to take stock and found there had been duplication, overlapping, and gaps left in service coverage. For example, MSH found while training the second class of BHWs, that 52 percent of the first two classes had been recruited from only six of the twenty-nine provinces. MSH secured AHC agreement to compensate for that in succeeding classes. The fact remains, however, that BHWs are still being trained to respond to requests from commanders and parties, and too frequently are deployed without regard to hierarchal relationships, including supervision. MSH and the MOPH then are still contributing to "anarchy". The Review Team recommends that MSH support for training BHWs for deployment to areas which are not actively developing hierarchal services should be limited at the end of training of the current batch (eighth BHW training session now in progress), and that at least eighty percent of all future BHW training (including refresher training) be conducted within a framework of a system, be it area or provincial, which will link the BHW to a supervisory, reporting and monitoring hierarchy. The Team initially believed that all BHWs should be deployed to hierarchal systems, but was persuaded by arguments based on equity and humanitarian concerns. We believe USAID should consider applying the same formula with its PVO grantees, for training of all levels of health workers and for support of additional clinical facilities.

(B) MSH and Ministry of Public Health Working Relationships

"Can MSH and MOPH working relationships be better structured?"

From all we have seen and heard, we think this relationship is cordial and appropriate. It is close enough for maximal benefit yet pliable enough to permit MSH flexibility when MSH and MOPH objectives are not congruent. It might improve even more when MSH secures the services of a very senior Afghan health coordinator to further assist the interface with the AIG/MOPH and the Afghan professional community. The Review Team recommends that MSH more actively pursue the recruitment of a senior Afghan coordinator than has been the case since the 1988 evaluation recommendation, and further, that USAID require MSH to establish a deadline for this recruitment as part of an approved 1990 Work Plan.

As noted elsewhere, MSH is the largest US health grantee and, as such, is a natural target and scapegoat for the PVOs. MSH should communicate and coordinate with the PVOS to a greater extent. Communications should include clear identification of which initiatives are Afghan and which MSH's.

(C) Transfer of Responsibility to Afghan Entities

"Can MSH, at this time, delegate more responsibilities to the MOPH and/or to Area Health Committees?"

We believe that MSH carefully has structured its relationships with the MOPH similar to the way a responsible AID contractor in another country would with a sovereign government. It does not delegate to the government, it cooperates to the extent possible within its agreements with that government. Having said that, MSH might save itself a little grief from the PVOs and UN organizations by more strongly resisting the MOPH tendency to have MSH be its spokesman. Additionally, MSH should initiate a dialogue with the MOPH concerning the MOPH assuming responsibility for providing salaries. We believe that the likelihood is low for any Afghan government having resources for this purpose in the foreseeable future without outside assistance.

The Review Team did not examine or observe MSH relationships with the Area Health Schemes.

VI. FINANCIAL AND FISCAL SUSTAINABILITY

(A) Review of the MSH Developed "Sus-Plan"

> "Review the MSH-developed report "Planning Sustainable Health Services in Afghanistan" ("Sus-Plan") on the financial side, evaluate the plan in light of its overall effectiveness, over the long term, to guide government authorities to implement a sustainable, affordable health delivery system."

In the following discussion, the Team differentiates between the terms "self-sustainability" and "sustainability". "Self-sustainability" refers to support of a post-war Afghan health system by resources, public and private, from Afghan sources only. The Team is unaware of a single country approximating Afghanistan's level of development which has a self-sustained health system anywhere near the WHO/UNICEF goal of "Health for all by the year 2000". The term "sustainability" herein refers to support of a post-war Afghan health system resulting from a combination of Afghan public and private resources AND total expected levels of donor support from all sources. Prior to 10 year's devastation by war, Afghanistan widely was included in the category of "poorest of the poor" nations, and attracted deserved donor assistance from multi-lateral, bilateral and private organizations. It is reasonable to assume (and we have done so), that assistance of this sort will again be provided to post-war Afghanistan for some prolonged period to help sustain an Afghan health system.

The "Sus-Plan" developed by MSH is a useful guide to an APPROACH to working on sustainability for the Afghan health system. It is not a plan for sustainability and should not be viewed as such. The approach to sustainability in this document must be combined with the various monitoring systems outlined in 4 A above to get a picture of the health system required for post-war Afghanistan. Only when staffing and facility guidelines have been agreed upon for such a system, can an accurate picture be available of the costs of operating the system.

In the meantime, special operations research projects need to get underway to get a picture of the real costs associated with the delivery of health services required to treat the major diseases extant in Afghanistan and to deliver the critically needed preventive health services required to reduce the level of ill health.

The Team recommends that MSH and/or USAID bring to Peshawar experts in developing country health care financing so the MOPH and PVO community can be exposed to expert discussion in this important area. The MOPH needs to be convinced that it cannot afford a free health care system with a large network of curative

hospitals at the apex. Operations research concerning fee-for-service and fee-for-medication at all levels of the health system needs to begin now. As part of that process, the Review Team recommends that USAID provide consultant assistance to its grantees (and other interested parties) in the uses of social-marketing as a method of cost-sharing between government and private sources.

It should be made clear to all that USAID plans not to continue funding recurrent salary costs on a long term basis. Planning for a phase-out and transfer of USAID support for salaries should be an ongoing activity of every O/AID/REP and AID/W health grantee, although a very careful phase out must be planned to prevent damaging the relationships so carefully established.

Please also see Part VI B below.

(B) Cost Cutting and Fee-for-Medication

"Examine project expenditures for pharmaceuticals and medical equipment and determine if there are ways to cut costs while maintaining quality service. Assess possibilities to cut types and/or quantity of medicines provided. Investigate the possibility to charge for some (high demand) pharmaceuticals to allow market forces to provide certain medicines, in lieu of the government/PVO systems of delivery."

CUTTING COSTS:

MSH, along with every USAID-funded PVO, WHO and all other NGOs and PVOs whom the Review Team contacted, has agonized excessively over these questions, individually and collectively. There are no simple answers, and the following points should be kept in mind as we look at some of the issues:

- When MSH started operations, the only supply list available that had any degree of standardization was the list supplied by the Swedish Committee for Afghanistan (SCA). The list was unacceptable for MSH use at the time because it contained drugs/medications: not approved by the Federal Drug Administration (FDA); available from sources (e.g., China) not approved by USAID procurement regulations; and which if locally procured could not reasonably be stored and transported without severe wastage (e.g., hydrogen peroxide). Pressure was on to move personnel and material across the border. MSH constituted a list similar to the SCA list but one which accommodated the constraints mentioned above. There was not an identical match then nor has there ever been since. (The question arises whether the SCA could be called upon to provide all pharmaceuticals and

supplies to USAID grantees in the event of future budgetary constraints. Because not all the constraints mentioned above have been eliminated, the fill-time for SCA pharmaceutical requests is usually considerably slower than the current MOPH system, and because of the advantages of not depending on a single medical logistic system (planned redundancy), the Review Team views this as a sub-optimal alternative. The Team recognizes, however, that circumstances may dictate future consideration of this alternative).

-Attempts at standardization notwithstanding, each organization training health/medical workers for assignment inside Afghanistan trains them in different ways for different tasks and with different responsibilities. Most other organizations which use the SCA list as their basic list supplement it, usually with both supplies and medications. They do not have their total lists as easily available for inspection (and possible criticism) as does MSH.

-MSH elected the developmental mode of attempting to coordinate its activities with recognized Afghan authority to a much greater extent than did many of the PVOs (see Part V A above). Accordingly, it negotiated with curative-minded Afghan medical practitioners in the AHC (from 5 parties and at least as many medical specialties) to arrive at an acceptable list. Anyone who has gone through this process (as have some members on the Review Team) realize what a laborious process this is -starting from a multi-specialty wish-list of literally hundreds of items and attempting to pare it down to any reasonable shape while retaining the items which international experience has shown should be included for PHC (for example, ORS, which clinicians either haven't really heard of or have any experience with, or soap, which they assume somehow will be available locally). Many PVOs were able to minimize this process by getting single-source experienced international medical opinion and starting operations with little or no consultation. This was particularly true at the beginning of assistance when war and disaster relief was the overwhelming, if not sole, priority.

The foregoing is not to diminish in any way the problems or accomplishments of the PVOs. It has been included to indicate that MSH chose to work closely with Afghan professionals which represented political entities. What has resulted is a compromise list which does differ in content and amount from the SCA list and from the suggested standards put together by the Coordination of Medical Committees (CMC). MSH participated heavily in the difficult CMC deliberation process.

-There are and will remain for years to come significant amounts of war related trauma, including injuries caused by mines. Some medications and equipment (for example injectable penicillin and an injectable pain-killer) can markedly influence

the comfort level and life expectancy of a severely injured individual who has to be transported any distance for other than emergency care. MOPH-trained BHWs have such preparations and have been taught to use them. MSH argues that whereas these items (and others) might not be appropriate for a BHW in most countries, they are appropriate in Afghanistan today. The Review Team does not have information to refute this.

-The MSH staff in Peshawar is an exceptional mix of professionals, containing experts with long experience in a variety of developing countries (at war and in peace) and professionals with several years of recent first hand in-country (Afghanistan) experience, as familiar as any expatriates with the medical situation which exists and with the capabilities of the BHW. This group has continually worked to refine the supply and equipment list to match need with capability in order to respond cross-border realities. The group has given a high level of professional concern to the supply and equipment list, and undoubtedly will continue to do so.

-The medical logistics system developed by MSH is imperfect, and again, is a compromise reflecting the reality of management of a program from outside the country. MSH is the first to admit this. It largely is a supply-driven system, unable at this time to respond well to individual circumstances, or even to a large extent to differences in geographic or regional needs. Additionally, the supervision and monitoring of the system suffers when compared to the more traditional USAID-supported medical logistics system. We believe that MSH is controlling this about as well as it can under the circumstances, but unquestionably there are costs associated with this kind of a situation. MSH plans to modify the logistics system in the Area Development Schemes to develop a more demand-driven system, and can do so in the province-level schemes as they are developed. (While on the subject of medical logistics, the MSH Team states it is getting excellent support and cooperation from the O/AID/REP RONCO contract).

With the foregoing in mind, our answer to the first part of the question ("Is it possible to cut costs, and cut types and amounts of medicines while maintaining quality service?") is, "Yes, it is possible". The problem is, that every professional group or individual that is asked, "What is the best way to do this?", is going to provide a perfectly reasonable and professional, but DIFFERENT answer (for example, on the Review Team there was considerable professional difference of opinion concerning the advisability of providing Metronidazole to the BHW). The Review Team strongly believes that the on-site MSH Team, supplemented easily by the backup available to it, is working on these issues on almost a daily basis, and is doing so in a responsible and professional manner. While USAID can (and should) continue to make its concerns known to the MSH Team, the

Review Team recommends that the task of determining the appropriate make-up of medical supplies and equipment be left to the professional judgement of the MSH team with a minimum amount of outside second-guessing. If USAID wishes, it can, of course, request MSH to secure an expert group (or USAID can call upon AID/Washington to constitute a group) to render a "second opinion". We believe that much time, effort and expense will go into such an effort, and very little benefit will accrue.

CHARGING FOR MEDICATIONS

The Review Team was told that before the war, for every dollar the Government of Afghanistan spent for health, the Afghan people spent seven dollars, and that very few medicines were provided free by the government. A simple answer, then, might be, "Yes, it is possible to charge for some drugs as a method of cost reduction". Related questions would consider the method and timing for doing this, some practical concerns, and the possible associated social and political costs.

We are told that drugs of all sorts are now available literally throughout Afghanistan. They have been provided in great amounts and variety by the international donor communities and PVOs for humanitarian and war-relief reasons, usually free of charge as a matter of policy, but also as a method for garnering support for Afghan groups (for example, the Mujahideen or AIG) for political reasons. Huge quantities have been provided by communist and other sources, presumably for similar reasons on the behalf of a different constituency. Finally, the private sector has responded to the stimulated demand in a predictably entrepreneurial manner.

Some organizations contacted said that if the US Government requires of its grantees that they institute a fee-for-medication policy, the move may be interpreted as a change in attitude toward the AIG and run the possibility of some political backlash. The argument (right or wrong) is presented that the people in Afghanistan might seek medication from sources not friendly to the AIG, and somehow come under the political sway of that other group. Many US and other PVOs under their mandates may be unable to charge for any form of service. Others may refuse to do so.

Practical questions which need to be answered (and the Review Team freely admits its inability to do so) include:

If the US chooses to insist on the introduction of charges for medications and presumably supplies, will it apply charges for all medication/supplies, or will categories be excluded such as casualty-care and PHC interventions including immunizations of mother and children (including the vaccination record kept at home), or ORS salts for childhood diarrheas?

Is the US Government prepared to agree on the usage of proceeds from fees for the medications? What will be the provision for those unable to pay?

How will all the foregoing be monitored with any degree of fiscal responsibility?

These are but a few of the superficial concerns which should be considered before a decision is made to begin to institute a fees-for-medication policy. A defensible position for the Review Team is to suggest that the timing for a decision might be more appropriate after the move to Kabul, but not without noting that we have been told that there are a few precedents for fee-for-medications: there is a PVO (LEPCO) dealing with leprosy that quietly has continued its leprosy control efforts with some sort of a minimal payment scheme in the predominantly Shiite areas, and some Medecins Sans Frontieres (MSF) hospitals that have been pressured into a partial fee-for-service by their communities. We did not have time to pursue information on these. The Team doesn't believe that MSH or any PVO can make what amounts to a major policy decision concerning fee-for-medications alone. Each can contribute ideas, and we believe AID and others US agencies should solicit these thoughts. In the end, however, we believe this is a US government policy issue, and when a policy is established, those US-funded organizations involved in cross-border assistance will deal with it the best way they can.

Please refer to the recommendations made in Part VI A above concerning operations research in this subject, as well the suggestion to explore social marketing.

(C) MSH Expenditures against Program Priorities

> "Examine the MSH budget to determine whether funds are being spent in correspondence to stated program priorities."

Program priorities have been altered somewhat since project inception, from an "aggressive implementation" mode for expedient relief of war wounded to a more planned developmental mode providing increasing support to civilians suffering from non-trauma complaints with an emphasis, to the extent possible, towards children and women. With this in mind, comparisons of fund expenditures with program priorities from project commencement to date would not lead to any useful conclusions. The Review Team, therefore, has used existing HSSP priorities (termed "major tasks") as stated in MSH's Cooperative Agreement (Amendment No. 4) which resulted from the 1988 evaluation and subsequent AAM, and compared these six major tasks with FY 1990

EXECUTIVE SUMMARY

INTRODUCTION

The Health Sector Support Project was authorized on August 8, 1986 to: a) rapidly expand the availability of primary health care and first aid services inside Afghanistan; and b) assist in the development of the capability of the Alliance Health Committee (later the Ministry of Public Health of the Interim Government of Afghanistan) to plan and manage expanded health care services and participated in the eventual reconstruction of Afghanistan.

A Cooperative Agreement was executed with Management Sciences for Health (MSH) which established a technical advisory team in Peshawar, Pakistan in January, 1987. In August, 1988 an external evaluation was laudatory of the MSH accomplishments and recommended, inter alia, that the project be continued with MSH support. At the time of AID's deliberative process concerned with the renewal, the Soviets had announced a schedule for extraction of their forces from Afghanistan. AID approved continuation of the Project through December, 1992, at higher levels of funding (approximately $60,000,000 for the life-of-project). AID Washington required a Project Review 18 months after approval of the AAM, and it was in response to that requirement that a team (the Review Team) conducted this review in January and February, 1990.

The MSH Cooperative Agreement was amended in February, 1989. The revised project purposes are:

1. Improve first aid and emergency services including medical and surgical care for war casualties, phasing down as the need subsides.

2. Expand general health care services for civilians including women and children as well as Mujahideen (Afghan "Freedom Fighters").

3. Enhance the capability of the Alliance Health Committee, other organized Afghan entities (private or public) and/or organized areas to plan, organize and manage expanded health care activities.

Six major tasks were assigned, including: development of area (regional) health systems; execution of primary health care services; development of Afghan health-training capability; work with Afghan groups to develop pilot activities designed to involve the population in supporting the costs of rural health care services; develop Afghan capability in medical supply and logistics; and, creation of Health Information and Management Information Systems (HIS/MIS).

planned program expenditures. (The comparison excludes TA and grantee logistic costs.) This comparison, we feel, will give the clearest idea of MSH adherence to defined program priorities. (Comparing FY 1990 planned expenditures, as opposed to FY 1989 actual expenditures, provides more practical information, as any perceived disparities can be corrected by MSH modifying its implementation/expenditure plans.

A summary of the major tasks in the 1989 amended MSH Cooperative Agreement, and the estimated percent of planned FY 1990 program fund expenditures (approximately $11,000,000 in FY 1990) attributed to each task, are as follows:

TASKS:

1. The planning, development and implementation of adequately managed health delivery systems within Afghanistan. (62.3 percent).

2. The planning and execution of primary health care services, and disease control programs: for maternal care, immunizations, oral rehydration therapy (ORT), malnutrition, acute respiratory infections (ARI), malaria, and tuberculosis. (12.6 percent).

3. Development of the capacity of the MOPH and Area Health Delivery Schemes to set up and run local and area training centers in their regions/areas. (13.8 percent).

4. Develop and implement pilot self-help activities designed to involve the population in supporting the costs of rural health care services, and encourage public and private sector cooperation in responding to the continuing need for basic medicines and supplies. (1.5 percent -- development only.)

5. Work with the MOPH and Area Health Schemes to develop their capacities to plan and manage the medical procurement process, determining the type and quantity of supplies required, their distribution, and system for supply and resupply. (3.1 percent).

6. Create a viable Health Information System (HIS) and Management Information System (MIS) capable of monitoring and evaluation as well as carrying out operational research and surveys. (6.5 percent).

The above task and expenditure comparisons prove an impression of program priorities. What is left out, but which is of significance, is the distribution of TA costs and efforts. Unfortunately, attribution of TA costs is not possible at this time.

Overall, it is the Team's impression that funds generally are being spent in correspondence to stated program priorities. Admittedly, a statement such as this (or even the reverse) cannot be presented confidently because program priorities are not clearly stated, in either the AAM or the Cooperative Agreement.

Building on recommendations made elsewhere in this Review Report, and following the above comparisons, the Review Team recommends the following:

1. More funds and effort should be directed towards working with Afghan authorities to plan and begin implementation of sustainable health services in Afghanistan. (Task No. 4).

2. When the time is appropriate, and as signaled by the O/AID/REP, more emphasis should be placed on "institutionalization", the careful transfer of responsibility for systems and operations to Afghan authorities, as described in Tasks Nos. 5 and 6.

3. The program priorities of HSSP should be restated and more narrowly focussed to bring them up-to-date and make them clear and measurable. The restated, verifiable objectives should be made part of an amended Cooperative Agreement to be prepared prior to the end of June, 1990.

4. MSH and USAID should develop an accounting system so that planned expenditures could be keyed to tasks called for in an amended Cooperative Agreement (in addition to the current system which keys expenditures only to administrative "Cost Centers"). This will be useful both to MSH and USAID in monitoring and evaluating project activities.

VII. BEYOND THE SCOPE OF WORK

The Review Team has some thoughts which were not included in the SOW, but which relate to the topic at hand:

1. Health grantees working in Afghanistan and the Committee for Medical Coordination (CMC).

The Review Team looked at the need for coordination among the various health organizations, grantees and others, working in Afghanistan and the role played by CMC in coordination.

CMC presently has 12 members, five of whom are funded by O/AID/Rep: FM, IMC, MSH, MCI and MTA. Team members interviewed representatives of 10 of the 12 member organizations and attended a special CMC meeting arranged especially for this review. CMC's

membership includes most Western "cross-border" health PVOs, with the notable exception of GAC. (The Team did interview the Director of GAC; this PVO continues to receive significant amounts of AID funding.) CMC's membership does not include the Arab-funded PVOs, some of which might not join because CMC's charter prohibits members from engaging in "political propaganda or religious proselytism..." CMC presently has close working relations with UNICEF and WHO.

While the Team is in no position to evaluate the quality of any PVO health programs inside Afghanistan -- the focus of this Review was MSH -- we can make an assessment on the need for coordination among them and the role CMC could play.

When interviewed separately, CMC members were split on whether the continuation of CMC would make a difference. No one interviewed (excepting GAC) saw ACBAR as an effective vehicle for cross-border coordination, basically because ACBAR is "too big", the concerns of cross-border PVOs are "diluted by NGOs with only refugee program concerns", and ACBAR "has no focus." Some NGO's saw the WHO Program for Afghanistan as a coordinating mechanism, but thought it had drawbacks because it was a UN organization, officially recognizing only the government in Kabul, and being occupied with many more operational responsibilities than is typical of WHO.

The Review Team believes that there is a critical need to have a formal coordination mechanism for those entities running cross-border health programs. If CMC withers away, as it may (we have been told that UNICEF will discontinue funding and O/AID/Rep is considering the same), we can see the need for an organization very similar to CMC being "re-invented" from scratch.

The Review Team recommends that O/AID/Rep consider continued funding for CMC if the majority of its members (particularly the five U.S.-funded members) seriously want it to continue. (The team understands that the CMC board meeting, scheduled for 2/21/90, will address continued funding and the overall future of CMC.)

The Review Team recommends that the O/AID/Rep consider offering CMC a matching grant to fund one half of the Committee's operations for 1990 -- the other half of the operation costs would come from membership dues. Estimated CMC operation costs are small, about $100,000. We suggest that one-half of this amount would be put up by the CMC members, perhaps on a sliding scale for each member's total program costs. At present, each member's dues are approximately $1,200/year, totaling $14,400 annually from the members. If this total from members were increased from $14,400 to about $50,000, this, we believe, would indicate sincerity on members' part to keep CMC viable. If the

CMC members contribute one-half of the operating costs, and if the CMC members indicate a focus on important standardization and monitoring issues (as indicated by CMC's proposed annual agenda), then the Team recommends O/AID/REP's provision of matching funds for CMC operation. The Team believes that a strong, active and productive coordinating body will attract other donor funds -- even perhaps additional AID/Rep funds --for specific tasks such as monitoring and mapping.

2. If it is not being done, we believe someone should thoroughly inventory trained health personnel in the refugee camps to permit their inclusion in planning for post-war health care in Afghanistan. Similarly, some collection of known health assets existing in Kabul and other urban areas, as well as other known health assets, such as health workers trained by Iran and the USSR, would be helpful for planning purposes.

VZCZCILI *
PP RUEHC RUFHKA RUSBPW
DE RUEHIL #7546/01 353 **
ZNR UUUUU ZZH
P 191045Z DEC 89
FM AMEMBASSY ISLAMABAD
TO RUEHC / SECSTATE WASHDC PRIORITY 8295
RUFHKA / AMEMBASSY DHAKA 9741
INFO RUSBPW / AMCONSUL PESHAWAR 3251
BT
UNCLAS SECTION 01 OF 04 ISLAMABAD 27546

FILE

CLASS: UNCLASSIFIED
CHRGE: AREP: 12/15/8
APPRV: AREP: LCRANL
DRFTD: AREP: DPALM
CLEAR: AREP: JMMILL
ING/TEIGHMY,,
RDEBRUCE
DISTR: AREP 3 AMB DC
ORGIN: OCR

AIDAC FROM AID/REP

AID FOR ANE/AF, ALSO ANE/TR/HPN M. JORDAN
DHAKA FOR S. KELLER

E.O. 12356:N/A
TAGS: N/A
SUBJECT: AFGHANISTAN - HEALTH SECTOR SUPPORT PROJECT (HSSP) (306-0203) REVIEW

REF: (A) STATE 396737, (B) ISLAMABAD 25583, (C) STATE 369823, (D) ISLAMABAD 22672, (E) 88 ISLAMABAD 023766

1. THIS CABLE RESPONDS TO REF (A). PROPOSED SCHEDULE GIVEN LOOKS GOOD. AID/REP WILL HAVE TEAM'S SCHEDULE PREPARED FOR A 1/21 START. DETAILS OF THE REVIEW ARE GIVEN BELOW.

2. SUMMARY: THE REVISED AAM (ACTIVITY APPROVAL MEMORANDUM) FOR SUBJECT PROJECT WAS APPROVED SEPTEMBER 30, 1988. AT THAT TIME AN INTERNAL REVIEW WITH AID/W PARTICIPATION WAS PLANNED (REF D). THIS REVIEW FOLLOWS A FULL EVALUATION COMPLETED DURING AUGUST, 1988. THE REVIEW WILLNOT ONLY FOCUS ON ISSUES RAISED DURING THE 1988 EVALUATION, AND SUBSEQUENT AAM AMENDMENT, BUT IT WILL ALSO LOOK AT ISSUES WHICH HAVE ARISEN OVER THE LAST YEAR AND ONE HALF AND AT PROJECT IMPLEMENTATION PROGRESS SINCE THE 1988 EVALUATION. A DETAILED REVIEW SOW IS GIVEN IN PARA 4 BELOW. THE REVIEW TEAM WILL ALSO CRITIQUE THE MANAGEMENT SCIENCES FOR HEALTH'S (MSH) CY 1990 WORKPLAN (WHICH WILL STILL BE IN DRAFT), AS IT WILL CONTAIN MANY PROPOSED ACTIVITIES WHICH IMPINGE ON ISSUES TO BE ADDRESSED DURING THE REVIEW.

3. PER REF (A), O/AID/REP HEREIN PROVIDES BUDGET AND SOW INFORMATION SO THAT ANE/TR/HPN CAN COMPLETE A PIO/T TO FUND DR MERRILL SHUTT UNDER THE JSI IQC. OE FISCAL DATA IS ALSO INCLUDED FOR JORDAN, STUDZINSKI AND KELLER.

4. BUDGET INFORMATION:
- A. PER REF (B), O/AID/REP REQUESTS AID/W TO DO PIO/T FOR DR. SHUTT. THE PIO/T FISCAL DATA FOR DR. MERRILL SHUTT, (JSI IQC) ARE: FUNDS ARE FROM THE TECHNICAL SUBJECT, NO. 306-0202: APPROPRIATION 72-1101021; ALLOTMENT QDNA-93-27326-KG13. PIO/T NO. 306-0200-3-00002. (PER PARA 1, REF (A) TWO DAYS TDY IN AID/W IS APPROVED.)

- TRANSPORTATION: DOLLARS 3,450
- FULLY BURDENED RATE, DOLLARS 285.78/DAY FOR 25
- DAYS: DOLLARS 7,145.
- PER DIEM: DOLLARS 2,505.
- CONTIGENCY EXPENSES (IN COUNTRY TRANSPORTATION,
- REPORT PREPARATION, ETC.): DOLLARS 2,000.
- TOTAL: DOLLARS 15,100.
-
- B. FOR AID DIRECT HIRE (OE FUNDS):
- APPROPRIATION 72-1101000
- BUDGET PLAN CODE: COEA-90-27306-U000
- MICHAEL JORDAN (AID/W)-0BLG NO. X000072;
- (2 WEEKS)
- TRANSPORTATION: DOLLARS 3,300.
- PER DIEM: DOLLARS 1,280.
- NICK STUDZINSKI (AID/W)
- (10) DAYS) - OBLG NO. X000073;
- TRANSPORTATION: DOLLARS 3,300.
- PER DIEM: DOLLARS 310.
- SHERYL KELLER (USAID/DHAKA)
- (2 WEEKS)-OBGL NO. X00074
- TRANSPORTATION: DOLLARS 790.
- PER DIEM: DOLLARS 1,280.
- TOTAL: DOLLARS 10,760.

(PER DIEM WHILE IN PAKISTAN WILL BE IN ACCORDANCE WITH MISSION ORDER NO. PAK 22-2, AS AMENDED. TRAVELLERS SHOULD HAND CARRY COPIES OF THEIR TA'S FOR MISSION RECORDS.)

5. HSSP REVIEW SOW: THE DETAILED SOW, BELOW, IS FOR THE ENTIRE REVIEW TEAM OF: DR. SHUTT, JSI, TEAM LEADER; MICHAEL JORDAN AND NICK STUDZINSKI, ANE/TR/HPN; SHERYL KELLER, USAID/DHAKA; AND DOUGLAS PALMER, O/AID/REP.

- A. ACTIVITY TO BE EVALUATED - BACKGROUND:
- THE HEALTH SECTOR SUPPORT PROJECT (306-0203) WAS INITIATED IN 1986 TO EXPAND PRIMARY HEALTH AND FIRST AID SERVICES INSIDE AFGHANISTAN WHILE ASSISTING THE ALLIANCE HEALTH COMMITTEE, NOW THE MINISTRY OF PUBLIC HEALTH OF THE AFGHAN INTERIM GOVERNMENT (MOPH/AIG), AND AFGHAN REGIONAL AUTHORITIES, TO PLAN AND MANAGE HEALTH CARE SERVICES. TO HELP MEET THE MASSIVE HEALTH CARE NEEDS IN AFGHANISTAN, THE SEPTEMBER 1988 AMENDED AAM PROPOSED A REVISED LIFE OF PROJECT FUNDING OF DOLS 84,235,000 (SINCE SCALED DOWN TO DOLS 60,500,000 PER REF D) WITH A REVISED PACD OF DECEMBER 31, 1992. THE AMENDMENT WAS AUTHORIZED WITH THE UNDERSTANDING THAT: SERVICES WOULD BE EMPHASIZED IN UNDERSERVED AREAS WHERE REFUGEES ARE EXPECTED TO RETURN OR WHERE INTERNAL DISPLACEMENT OF POPULATION IS A MAJOR PROBLEM; THAT INSTITUTION BUILDING WOULD BE KEPT TO THE MINIMUM WITHOUT JEOPARDIZING A SOUND RESETTLEMENT HEALTH PROGRAM; THAT SALARIES WOULD NOT EXCEED APPROXIMATELY 30 PER CENT OF THE NEW OBLIGATIONS, WITH A PLAN TO PHASE DOWN A.I.D. SALARY SUPPORT IN THE FUTURE; AND THAT RECURRENT COSTS AND COST RECOVERY ISSUES ASSOCIATED WITH PROVIDING HEALTH SERVICES WOULD RECEIVE ONGOING ATTENTION.

IN A SHORT PERIOD, HEALTH SERVICES IN RURAL AFGHANISTAN AS WELL AS THE LOGISTICAL, ADMINISTRATIVE AND TRAINING SYSTEMS NECESSARY TO SUPPORT THESE SERVICES HAVE BEEN DEVELOPED. TO DATE THE PROJECT HAS TRAINED OVER 1,700 BASIC HEALTH WORKERS (BHW) IN A THREE-MONTH COURSE, GRADUATED OVER 15,000 FREEDOM FIGHTERS FROM A TWO-DAY FIRST AID COURSE, AND ESTABLISHED OVER 1,200 HEALTH FACILITIES IN ALL 29 PROVINCES OF AFGHANISTAN. THE TRAINING AND HEALTH FACILITY ACTIVITIES ARE ON OR AHEAD OF SCHEDULE. A COUNTRY PLAN FOR IMMUNIZATION HAS BEEN IMPLEMENTED IN SELECTED PROVINCES, AND A TRADITIONAL BIRTH ASSISTANT PROGRAM HAS BEEN DEVELOPED.

THE PROJECT IS BEGINNING TO ADDRESS EXPANSION OF THE REGIONAL HEALTH SYSTEMS AND THE STRENGTHENING OF MOPH CITY TO PLAN AND MANAGE AN EXPANDED PYRAMID OF HEALTH SERVICES INSIDE AFGHANISTAN. PRELIMINARY PLANS HAVE BEEN MADE TO ADDRESS THE CONTROL OF DIARRHEAL DISEASE, MALARIA AND TB. PROGRESS IN ESTABLISHING AND IMPLEMENTING OTHER MATERNAL AND CHILD HEALTH SERVICES, HEALTH AND NUTRITION EDUCATION, A HEALTH INFORMATION SYSTEM (HIS) AND A MANAGEMENT INFORMATION SYSTEM (MIS) ARE MORE PROBLEMATICAL.

- B. PURPOSE OF THE REVIEW:
- THE REVIEW WILL PROVIDE A DETAILED STATUS OF PROGRESS TOWARDS THE OBJECTIVES SET FORTH IN THE REVISED AAM, WHICH FOLLOWED THE FULL EVALUATION CONDUCTED IN 1988. THE HSSP REVIEW WILL FOLLOW ON AN EVALUATION OF THE MISSION'S PVO CO-FINANCING PROJECT, INCLUDING HEALTH ACTIVITIES, AND, THUS, WILL PROVIDE O/AID/REP AND AID/W WITH A RECENT LOOK AT THE ENTIRE HEALTH PORTFOLIO. (THE REVIEW TEAM MEMBERS WILL BE PROVIDED WITH THE PVO

CO-FINANCING EVALUATION RESULTS.) THE RESULTS OF THE REVIEW WILL ASSIST MSH TO FINALIZE ITS CY 1990 WORKPLAN AND ITS PRELIMINARY PLANS FOR CY 1991. ADDITIONALLY IT WILL ASSIST THE AID/REP TO ASSESS THE NEED, IF ANY, TO REDIRECT ASPECTS OF THE HSSP. THE REVIEW WILL ALSO HELP FINALIZE AID/REP PLANNING BUDGETS FOR FY 90 THRU FY 92 BASED UPON HISTORICAL AND PROJECTED QUARTERLY EXPENDITURE PATTERNS.

- C. STATEMENT OF WORK:
- (1) PROGRAM MANAGEMENT:
- (A) THE TEAM WILL REVIEW THE HEALTH, FINANCIAL AND CONTRACTURAL ISSUES INVOLVED IN THE MERGER OF AID/REP'S MSH AND PVO ACTIVITIES UNDER A HSSP UMBRELLA. THE TEAM WILL RECOMMEND IF SUCH A MERGER SHOULD BE MADE, AND IF SO HOW IT SHOULD BE ACCOMPLISHED - TO INCLUDE THE STRUCTURING AND TIMING OF A POSSIBLE MERGER.
- (2) HEALTH SERVICES DELIVERY:
- (A) ASSESS THE REGIONAL HEALTH DELIVERY SYSTEMS IN SHURA-E-NAZAR, SOUTH AND WEST, AND HAZARZAT, AND DETERMINE WHETHER THE DESIGN AND

IMPLEMENTATION OF THESE EFFORTS IS SUITABLE TO THE NEEDS, OPPORTUNITIES, AND CONSTRAINTS, AND JUDGE THE POTENTIAL FOR INTEGRATION OF THE DIFFERENT SYSTEMS INTO AN OVERALL HEALTH CARE SYSTEM FOR AFGHANISTAN, INCLUDING FACILITIES PRESENTLY OPERATED BY OTHER THAN AID FUNDED DONORS.

- (B) IT APPEARS MOST PVO HEALTH PROGRAMS ARE NOW BEGINNING TO DESIGN AND IMPLEMENT REFRESHER COURSES, IN PART TO OBTAIN A "MID-LEVEL" HEALTH WORKER (E.G., 6-18 MONTHS OF TRAINING). ARE MSH SHORT-TERM TRAINED (3 TO 4 MONTHS) BHW'S NO LONGER APPROPRIATE COUNTRY WIDE, OR IN SOME REGIONS? ARE THERE SUFFICIENT NUMBERS OF BHW'S NOW? WHAT ARE THE IMPLICATIONS OF THE STRATEGY TO PRODUCE MORE MID-LEVEL HEALTH WORKERS?

- (C) IS IT NOW THE TIME AND IS IT POSSIBLE TO STANDARDIZE AND PROVIDE COMPETENCY BASED CERTIFICATION TO THE DIFFERENT LEVELS OF HEALTH WORKERS? WHAT SHOULD BE THE HSSP ROLE IN THIS? HOW WOULD THESE ACTIVITIES BE IMPLEMENTED? WHO WOULD BE THE TESTING AND CERTIFYING AGENT?

- (D) SHOULD THE HSSP, AT THIS TIME, OPERATE "VERTICAL" (SOLE PURPOSE) PROGRAMS? REVIEW RECENT MSH/MOPH EXPERIENCE WITH ITS EPI PROGRAM. ARE VERTICAL PROGRAMS FEASIBLE, EFFECTUAL AND COST EFFECTIVE? IS THERE NOW SUFFICIENT INFRASTRUCTURE IN AFGHANISTAN, AND POPULATION CONCENTRATIONS TO WARRANT VERTICAL PROGRAMS? WHAT VERTICAL PROGRAMS (E.G., MALARIA, TB, ARI) SHOULD BE ATTEMPTED, IF ANY?

(3) TRAINING

- (A) IS THE CMC/WHO MINIMUM SKILLS LIST ADEQUATE? SHOULD MSH/MOPH FOLLOW THIS LIST IN ITS TRAINING AND ITS TECHNICAL MONITORING?

- (B) JUDGE THE QUALITY OF THE MSH/MOPH 3-MONTH BHW TRAINING PROGRAM AND THE 12-DAY REFRESHER COURSE TRAINING VIS-A-VIS WORLD HEALTH ORGANIZATION STANDARDS; AND JUDGE MSH/MOPH TRAINING PROGRAMS VIS-A-VIS THE PRESENT NEEDS IN AFGHANISTAN.

- (C) SHOULD O/AID/REP REQUIRE MSH/MOPH (OR REGIONAL HEALTH AUTHORITIES) TO PROVIDE PROOF (SPATIAL MAPS OF EXISTING HEALTH FACILITIES, ESTIMATED POPULATION DENSITIES, ETC.) BEFORE ALLOWING TRAINING OF ADDITIONAL PERSONNEL AND/OR THE ESTABLISHMENT OF NEW HEALTH FACILITIES?

- (D) SHOULD MSH SEND MORE GOVERNMENT HEALTH PROFESSIONALS OVERSEAS FOR SHORT-TERM TRAINING, SUCH AS IT DID WITH THE AID/MOPH TRAINING DIRECTOR, DR. FATIMIE?

-

- (4) MONITORING AND THE MANAGEMENT AND HEALTH INFORMATION SYSTEMS (MIS/HIS):

- (A) CAN MORE SYSTEMATIC USE BE MADE OF THE EXISTING MONITORING SYSTEM BY MSH, MOPH AND O/AID/REP TO PROVIDE EMPIRICAL BASES FOR TECHNICAL AND LOGISTICAL FUNDING DECISIONS?

-

- (B) ASSESS PROGRESS ON THE DEVELOPMENT OF THE HEALTH INFORMATION AND HEALTH MANAGEMENT SYSTEMS. ARE THE DATA THESE SYSTEMS ARE DESIGNED TO OBTAIN APPROPRIATE FOR PROGRAM MONITORING, DEVELOPMENT, IMPLEMENTATION, AND ANY NECESSARY REDESIGN?

- (5) INSTITUTIONALIZATION:
- (A) WHAT HAS BEEN MSH'S ROLE VIS-A-VIS THE PVO'S AND OTHER DONORS IN DEVELOPING AFGHANISTAN'S HEALTH CARE SYSTEM AND "STRENGHENING THE CAPACITY" OF THE AIG/MOPH TO PLAN AND MANAGE AN EXPANDED PYRAMID OF HEALTH SERVICES INSIDE AFGHANISTAN? SHOULD IT MAINTAIN OR ALTER THAT ROLE?

- (B) CAN MSH/MOPH WORKING RELATIONSHIPS BE BETTER STRUCTURED?

- (C) CAN MSH, AT THIS TIME, DELEGATE MORE RESPONSIBILITIES TO THE AIG/MOPH AND/OR TO REGIONAL HEALTH COMMITTEES?

- (6) FINANCIAL AND FISCAL SUSTAINABILITY

THE REVIEW TEAM AND SCOPE OF WORK (SOW)

AID constituted a four-person Review Team of two consultants (including the team leader) provided through an Indefinite Quantity Contract with John Snow, Inc., and two experienced AID health officers, one the Director of the AID/W technical office (ANE/TR/HPH) which backstops Afghan activities, and the other the Health Development Officer from the staff of the O/AID/REP.

The Scope of Work was very specific as to the questions that were to be addressed (see Attachment A). The questions fell within the broad categories of Program Management, Health Services Delivery, Training, Monitoring and Information Systems, Institutionalization, and Financial and Fiscal Sustainability.

METHODOLOGY

The team (except the O/AID/REP member) met in Washington January 15,1990 and was briefed on the project, current health activities, and upon a recently completed evaluation of some PVOs working in cross-border health activities in Afghanistan. All members were provided any Mission- and AID/W-provided background documents which hadn't caught up with them prior to the briefing.

After briefing by O/AID/REP Larry Crandall and his staff in Islamabad on Sunday, January 21, the entire Team moved to Peshawar, remaining there until through January 31. In Peshawar, the Team had initial meetings with the MSH staff and the Ministry of Public Health of the Afghan Interim Government, then separately or in groups met with many of the major UN organizations and PVOs involved in cross-border health assistance to gain their perspectives of the health situation in Afghanistan, a sense of their role in providing assistance, and the relationships of their efforts to MSH activities. Minutes were made of many of these meetings and were left with the Mission. (For a list of persons contacted, see Attachment B). Additionally, many sessions were spent with MSH staff in order to get the specific information useful in responding to the SOW. The Team met daily to coordinate activities, discuss issues, and later to review and react to draft portions of the report. On February 4, the Team made a verbal presentation to Mr. Crandall and his staff, and left with them drafted portions of the report. The Team got immediate feedback to its verbal and written draft, and spent a day in Islamabad (a suddenly-declared National holiday) discussing that feedback. Having already delayed their departures, two Team members (Jordan and Zopf) departed on February 5th and 6th. Two (Shutt and Palmer) returned to Peshawar, added and revised material, and met with the MSH Team on February 6th to get its reactions. The smaller Team then prepared the final report.

- (A) REVIEW THE NSH-DEVELOPED REPORT, "PLANNING SUSTAINABLE HEALTH SERVICES IN AFGHANISTAN" ("SUS-PLAN"). ON THE FINANCIAL SIDE, EVALUATE THE PLAN IN LIGHT OF ITS OVERALL EFFECTIVENESS, OVER THE LONG TERM, TO GUIDE GOVERNMENT AUTHORITIES TO IMPLEMENT A SUSTAINABLE, AFFORDABLE HEALTH DELIVERY SYSTEM.

- (B) EXAMINE PROJECT EXPENDITURES FOR PHARMACEUTICALS AND MEDICAL EQUIPMENT AND DETERMINE IF THERE ARE WAYS TO CUT COSTS, WHILE MAINTAINING QUALITY SERVICE. ASSESS POSSIBILITIES TO CUT TYPES AND/OR QUANTITY OF MEDICINES PROVIDED. INVESTIGATE THE POSSIBILITY TO CHARGE FOR SOME (HIGH DEMAND) PHARMACEUTICALS TO ALLOW MARKET FORCES TO PROVIDE CERTAIN MEDICINES, IN LIEU OF THE GOVERNMENT/PVO SYSTEMS OF DELIVERY.

- AS TIME PERMITS, THE TEAM SHOULD EXPLORE OTHER AREAS FOR POSSIBLE REDUCTIONS IN PROJECT COSTS.

- (C) EXAMINE THE MSH BUDGET TO DETERMINE WHETHER FUNDS ARE BEING SPENT IN CORRESPONDENCE TO STATED PROGRAM PRIORITIES.

6. METHODS AND PROCEDURES: THE REVIEW TEAM SHOULD ANALYZE KEY DOCUMENTS, INCLUDING: (1) THE 1988 HSSP EVALUATIONS (2) THE AMENDED ARM; (3) THE COOPERATIVE AGREEMENT BETWEEN O/AID/REP AND MSH; (4) THE SUS-PLAN; (5) THE HEALTH COMPONENT OF THE RECENT (11/89) PVO CO-FINANCING EVALUATION; (6) THE MSH CY 1989 AND DRAFT 1990 WORKPLANS; AND, (7) MSH'S 10-12/89 QUARTERLY REPORT. THREE SETS OF THESE DOCUMENTS (EXCLUSIVE OF THE MSH CY 90 WORKPLAN) WILL BE MAILED VIA APO, BY DECEMBER 31, TO ANE/TR/HPN FOR MIKE JORDAN, NICK STUDZINSKI AND DR. M. SHUTT. (PLEASE CABLE DR. SHUTT'S ADDRESS SO WE CAN SEND DOCUMENTS DIRECTLY TO HIM.) A FOURTH SET WILL BE AIR EXPRESSED TO USAID/DHAKA FOR S. KELLER. THESE DOCUMENTS SHOULD BE REVIEWED BY ALL TEAM MEMBERS BEFORE ARRIVAL IN PAKISTAN. (MSH WILL HAVE ITS CY 90 DRAFT WORKPLAN AVAILABLE FOR REVIEW WHEN THE TEAM ARRIVES.)

- THE TEAM MUST INTERVIEW ALL KEY O/AID/REP AND MSH EMPLOYEES, AND MUST ALSO HOLD INTERVIEWS WITH TMOPH, REGIONAL HEALTH COMMITTEE TEAM MEMBERS (BASED IN PESHAWAR), WITH RELEVANT PVO'S (BASED IN BOTH PESHAWAR AND QUETTA), AND WITH UN AGENCIES TO GET A FULL PICTURE OF THE EXISTING SITUATION.

- BECAUSE OF THE LENGTHY SOW, THE TEAM LEADER WILL ASSIGN EVALUATION ISSUES/QUESTIONS TO DIFFERENT TEAM MEMBERS; HOWEVER, THE ENTIRE TEAM WILL MEET AT LEAST ONCE EVERY TWO DAYS TO REVIEW THE ENTIRE SCOPE OF THE EVALUATION AND FINDINGS TO DATE. A 6-DAY WORKWEEK IS AUTHORIZED. ONE DAY WILL BE SPENT IN ISLAMABAD AT THE BEGINNING OF THE EVALUATION PERIOD AND ONE DAY AT THE END OF THE SECOND WEEK FOR DEBRIEFING, PRIOR TO THE DEPARTURE OF JORDAN AND KELLER. SHUTT WILL STAY, WITH STUDZINSKI, FOR THE THIRD WEEK - MOSTLY IN PESHAWAR - TO FINALIZE THE REPORT. DR. SHUTT HAS ULTIMATE

RESPONSIBILITY FOR COMPLETION OF THE ENTIRE FINAL
REVIEW REPORT. O/AID/REP WILL ATTEMPT TO PROVIDE
TRANSPORTATION FOR THE REVIEW AND SECRETARIAL ASSISTANCE

FOR THE FINAL REPORT; HOWEVER THIS MAY NOT BE POSSIBLE AND DOLS 2,000 (IN RUPEE EQUIVALENT) IS BUDGETED FOR IN-PAKISTAN TRANSPORTATION AND REPORT PREPARATION. THE TEAM SHOULD BRING AUXILIARY PORTABLE CALCULATORS, DICTATING MACHINES AND ONE OR MORE PERSONAL COMPUTER/WORD PROCESSOR (MULTIMATE AND LOTUS PREFERRED) TO REDUCE PRESSURE ON O/AID/REP STAFF AND EQUIPMENT.

7. THE FINAL REVIEW REPORT WILL INCLUDE DETAILED RESPONSES, INCLUDING RECOMMENDATIONS (AND CLEAR BASES FOR EACH RECOMMENDATION) FOR EACH OF THE QUESTIONS GIVEN IN THE DETAILED SOW (PARA 4, ABOVE). THE REPORT FORMAT WILL BE AS FOLLOWS.

- --EXECUTIVE SUMMARY
- --TABLE OF CONTENTS
- --BODY OF REPORT - TO FOLLOW SOW OUTLINE IN PARA 4, ABOVE OR AS AMENDED.
- --RECOMMENDATIONS
- --APPENDIXES (IF NEEDED)
- THE ENTIRE REPORT (EXCLUSIVE OF APPENDIXES) SHOULD NOT EXCEED 50 PAGES.

8. PLEASE ADVISE ETA OF SHUTT, JORDAN AND STUDZINSKI. REPEAT REVIEW TEAM'S ETA INFORMATION AS CONTAINED IN REF (A) TO USAID/DHAKA - IF NOT YET DONE - SO ZELLER CAN SCHEDULE HER ARRIVAL. AID/REP WILL PUT TOGETHER REVIEW TEAM'S SCHEDULE AND CABLE THIS NLT MID-JANUARY.
OAKLEY
BT
#7545

NNNN

ATTACHMENT B

Persons Contacted

Office of the AID Representative to Afghanistan (O/AID/REP)

Larry Crandall, USAID Representative
Jack Miller, Deputy USAID Representative
John Gunning, Chief, Program Division
Dr. Tom Eighmy, Chief, Education and Health Division
Demetria Arvanitis, Health Program Assistant
Hank Cushing, Regional Administrative Officer

Management Sciences for Health (MSH)

William Oldham, Chief of Party
Anwar Bajwa, Warehouse Manager
Vimal Dias, Commodity and Management Advisor
Mary Gasper, Financial Advisor,
Peter Huff-Rousselle, MSH Boston
Paul Ickx, M.D., Associate Medical Advisor
Richard Johnson, Training Advisor,
Laurance Laumoniere, M.D., Field Operations Advisor
Dr. Masood, Assistant Trainer
Dr. Mubarak, Training Officer
Linda Tawfiq, M.D., Women's Health & Health Education Advisor
Jonathan D. Quick, M.D., Health Services Development Advisor
Aziz Yousef, Commodity Receiver

Ministry of Health, Afghanistan Interim Government

Dr. Najibullah Mojadidi, Deputy Minister of Health
Dr. Barakzai, Deputy Minister of Health
Dr. Fatimie, Director , Public Health Institute
Dr. Safi, Director, Basic Health Services
Dr. Siddiqui, Deputy Director, Department of Curative Medicine

United Nations

WHO Afghanistan Program, Peshawar

Rudi Coninx, M.D., Coordinator,
Sharon McDonnell, M.D., Training Advisor
M. Roshna, M.D., Training Advisor, WHO Afghanistan

UNICEF Program for Afghanistan

Lief Rosenhall, Representative

Operation Salam, Peshawar Office

Michael Keating, Representative

Private Voluntary Organizations (PVOs, NGOs)

AVICEN

Phillip Truze, M.D., Director
Conrad Van Brabant, Assistant Director

Committee for Medical Coordination (CMC)

Jeffrey Paulsen, Executive Director

Freedom Medicine

Robert Brenner, Director,
Nancy Jamieson, Medical Director

German Afghan Committee

Dr. Reinhold Eroes, Director

International Medical Corps (IMC)

Todd Peterson, Director
Margaret Bowden, M.D., Medical Director

Medecins Sans Frontieres (MSF)

Bernard Chomilier, Director

Medical Training for Afghans (MTA)

Christian Gravet, Administrator
Elisabeth Kind, M.D., Medical Director

Mercy Corps International (MCI)

Mella Leiter, Medical Director

ATTACHMENT C

Major documents referred to by the Review Team

1. MSH Quarterly Report - June 1 to Sept. 30, 1989.

2. MSH Quarterly Report - Oct. 1 to Dec. 31, 1989.

3. Activity Action Memorandum (AAM), dated September 30, 1988.

4. Afghanistan Health Sector Support Project Assessment (Project No. 306-0203), ISTI, Vincent Brown et al, dated August, 1988.

5. AID Evaluation Summary, dated 2/28/89.

6. List of Health NGOs Supported by UNICEF (undated).

7. Development Potential for AID Projects Targeting Afghan Women, Kerry M. Connor, Ph.D., November 1989, Swedish Committee for Afghanistan.

8. "Phases for Provincial Health Services Development", MSH (draft 12/89).

9. Planning Sustainable Health Service in Afghanistan: An Approach, MSH,. August, 1989.

10. WHO Training Coordinator Report - Afghanistan, May, 1989, S. McDonnell, MD. (WHO Introduction to Health Workers Levels and Training.)

11. SCA Pharmaceutical lists "F" "O" "N" "D" (1989).

12. MSH Pharmaceutical lists (19), dated 1/23/90.

13. Work Report of the MOPH/AIG, dated 10/23/90.

14. Survey Report from Wardak Province, Dr. Siddiqullak Weera, Provincial Health Director Wardak Province, MOPH/AIG, dated 10/89.

15. CMC Monitoring Report No. 2, dated 8/88.

16. CMC General Report on Monitoring (undated).

17. MSH FY '90 Workplan (draft) dated 1/21/90.

18. Cooperative Agreement (O/AID/REP - MSH) No. 306-0203-A-00-6014-00 dated Sept. 22, 1986 and Amendments 1 through 6.

19. ACBAR HEALTH STANDARDS AND GUIDELINES The Community Health Worker - Published by WHO.

20. FIRST AID FOR COMMUNITY HEALTH WORKERS IN DEVELOPING COUNTRIES, by Muriel Skeet, published by ICRC.

21. Practical Guide to Common Illness in Afghanistan, published by CMC.

22. WHO Training Coordinator Report Afghanistan, May 1989, by S. McDonnell, MD.

23. WHO Introduction to Health Worker Levels and Tarining.

24. Health Development in Rural Afganistan MCH and Public Health Education Sociological Field Review by Anne Macey, MSH.

25. MSH Training Briefing Manual, 1990.

26. IMC Training Curricula.

27. FM Training Curricula.

28. CMC 1990 Operation Proposal, dated 12/15/89.

29. CMC, 1990 Operation Proposal, dated 12/15/89.

30. Managing Health Systems in Developing Areas, Experiences from Afghanistan, Ronald W. Connor, 1980.

ATTACHMENT D

FINAL SCHEDULE FOR HSSP REVIEW TEAM

January 19, FRIDAY

Dr. Merrill Shutt, Michael Jordan, Betty Lou Zopf arrive in Islamabad. Reservations at the Holiday Inn for Shutt and Zopf. Jordan stays with Swain.

January 20, SATURDAY

6:00 p.m.	Informal Dinner at the Palmers.

January 21, SUNDAY

Meetings at USAID:

9:00 a.m.	Larry Crandall, Jack Miller, Curt Wolters (Evaluation Officer) - with Eighmy and Palmer.
10:00 a.m.	Tom Eighmy, Doug Palmer, Demetria Arvanitis (Review SOW in detail.)
2:00 p.m.	Depart for Peshawar via road.

January 22, MONDAY

8:00 a.m.	Meet with Hank Cushing, RAO AID/REP, Peshawar
9:00 a.m.	MSH Staff (2:00 p.m. MOPH officials) All day.

January 23, TUESDAY

9:00 a.m.	Sharon MacDonald, WHO, 41509. Behind Azad Afghan Restaurant, Jamrud Road
11:00 a.m.	MOPH Training Center Visit - Shutt and Zopf
1:00 p.m.	Jeff Paulsen, CMC, 42093 25-C Circular Road
3:00 p.m.	Dr. Haider, Swedish Committee, 42218/40415 41-A Circular Road

January 24, WEDNESDAY

9:00 a.m.	Todd Peterson, IMC, 43512 Nazir Bagh
10:30 a.m.	MOPH Training Center at Mujahideen Camp - Shutt and Zopf

1:00 p.m. Bernard Chomilier, Medicins Sans Frontiere (MSF), 42349. 2 Park Lane

3:00 p.m. Dr. Reinhold Eroes, German Afghan Committee (GAC), 42588/42446
23-C Park Avenue Road

January 25, THURSDAY

9:00 a.m. Bob Brenner, Nancy Jamieson, Freedom Medicine, 42505/42512
4-A Railway Road

11:00 a.m. Christian Gravet, Medical Training for Afghans (MTA) 50891/2,
Hyatabad Admin. Enclave, Plot No. 34, Sector A3 (ITC Building)

1:00 p.m. Lief Rosenhall, UNICEF, 43669
17-B Abdara Road

3:00 p.m. Conrad Van Brabant/Philip Truze, AVICEN, 42493/43876
14-F Khushal Khan Khattak Road

January 26, FRIDAY

January 27, SATURDAY (Meetings with MSH offices and writing of report outline(s). All day.

January 28, SUNDAY

8:30 a.m. Meetings with MSh, all day. Shutt, Zopf, Palmer, Jordan

9:00 a.m. Michael Keating, UNOCA, 76602
Defense Colony. Jordan

January 29, MONDAY

Dinner - Mella Leiter, Mercy Corps, Quetta, is arriving today and will have dinner with the team.

January 30, TUESDAY

9:00 a.m. Joint meeting with CMC members and WHO representative at CMC Office, 25-C Circular Road (Set up by Dr. Bowden, IMC, Executive Board Director; and Jeff Paulsen, CMC Director, 43512)

1:00 p.m. Meetings with MSH Staff.

January 31, WEDNESDAY

All Day Meetings with MSH Staff

8:30 a.m. Meeting with Nancy Dupree, Afghan Resources Information Center (ARIC) - Zopf

2:00 p.m. Visit to Afghan OB/GYN Hospital - Zopf

February 1, THURSDAY

8:00 a.m. Write draft report sections.

2:00 p.m. Depart for Islamabad by car.

February 2, FRIDAY - Rest

February 3, SATURDAY

Team discussion on individual recommendations and finalizing draft report.

February 4, SUNDAY

2:00 p.m. Debrief AID/REP Officials (Conference Room)

February 5, MONDAY

Team revised draft report, following Sunday's debriefing of O/AID/Rep.

February 6, TUESDAY

7:00 a.m. Palmer and Shutt return to Peshawar
Jordan and Zopf departed from Pakistan

10:00 a.m. Meetings with MSH Staff to review draft report.

February 7, WEDNESDAY

8:00 a.m. Meetings with MSH Staff to review draft report.

February 8, THURSDAY

Finalize - review report. Depart for Islamabad.

February 9, FRIDAY

Shutt departed Pakistan.

MAJOR FINDINGS AND RECOMMENDATIONS

The following first and second comments appear within the text of our report, but the topic so affects the day-to-day operation of all USAID-assisted cross-border health assistance activities (and the review and evaluation of them), that we are giving them a place of some prominence:

Perhaps as important as any finding, the Review Team believes strongly that if the USG is serious about monitoring and wants to maintain credibility within the community supporting the provision of health services in Afghanistan (and within a much broader community as well), then the USG must lift the ban on travel inside Afghanistan by US citizens (including USAID Direct-Hire personnel) working with USAID-funded grantees. This Review Team belief was endorsed virtually unanimously by every USAID employee, grantee, PVO and UN official contacted.

The delays in moving the operational base of the Afghan Interim Government's Ministry of Public Heath into Afghanistan have, we believe, a deleterious affect on health status of the Afghan people,

Some general comments:

The Review Team was most favorably impressed by the scope, quality and variety of cross-border health activities supported by the O/AID/REP and AID/W, and commends all concerned for the flexibility and speed of response to legitimate humanitarian and political concerns. The MSH Team, which we have looked at in considerable depth, most certainly is included.

Comments, major findings and recommendations arising from the Review Team's responses to the specific questions asked in the Scope of Work follow. They are arranged in the same order as the Scope of Work.

I. PROGRAM MANAGEMENT

A. Merger of MSH and PVOs

The SOW question concerned the desirability and feasibility of administratively merging activities of USAID PVO grantees under an MSH umbrella. We believe such a merger would stifle innovation, reduce desirable competition, set a bad precedent for any future Afghan dealings with PVOs and reduce flexibility in response capabilities. A possible reduction in time required for USAID management of the PVO activities we thought would be minimal at best, and not sufficient to offset disadvantages of such a step.

-The Review Team recommends against a merger of MSH and PVO activities under an HSSP umbrella.

II. HEALTH SERVICES DELIVERY

A. Area Health Development Schemes

The SOW question asked the Team's assessment of three area schemes for health delivery which have been initiated in Afghanistan in response to cross-border Afghan initiatives. The schemes are rural in orientation, and are situated in geographic areas containing more than a semblance of Afghan civil authority. Of the three, the one in the North (Shura-e-Nazar) is the most fully developed. The schemes are supported by MSH, but not currently by the MOPH. MSH views assistance to these schemes as targets of opportunity, and fall-back positions for the provision of health care in the event further delays are encountered of a viable non-communist central government in Afghanistan.

The Team believes the potential for later integration of these Area Health Schemes into a national health system could be quite good if the schemes follow a health pyramid with the primary focus on preventive health care at the lowest outreach level, rather than a hospital-based curative program delivering free services which the areas (and Afghanistan) can ill afford to sustain. In contrast to some of the PVO health programs which seem to concentrate on hospital-based curative programs, these area schemes give every indication of a preventive health focus. The MOPH appointment of Provincial Health Officers of some provinces within these schemes sets in place the mechanism for direct links between important area programs and programs of the MOPH.

-The Team recommends continuation of active support of these schemes. MSH should try to stimulate the exchange of information between the MOPH and personnel of the Area Health Schemes in order that they may coordinate their plans for health systems development insofar as possible. It will also be critically important for PVOs that work in the provinces of the Area Health Schemes to ensure that what they are doing and the systems they are establishing complement the basic health systems being put in place by the various Area Health Schemes.

B. Basic Health Workers; Mid-level Workers

The SOW question concerns Basic Health Workers (BHWs) trained by MSH and mid-level health workers, largely curative in orientation, trained by a number of PVOs, some with USAID support.

The Team believes the BHW represents one of the few categories of health worker being trained with an orientation towards most elements of primary health care, and which offers reasonable potential for assuming a community health worker role post-war.

The Team believes that the BHW is appropriate for all rural regions of the country.

We recommend that:

-MSH should attempt to reach agreement with PVOs that the BHW is the appropriate health worker for the base of the health pyramid;

-Mechanisms must be greatly expanded for alleviating the near vacuum of MCH services within Afghanistan;

-Continued and expanded efforts must be made to train and deploy female BHWs;

-Experimentation with various hierarchal health delivery systems should continue in order to insure that BHWs are integral parts of a system, not independent practitioners.

-A planned and scheduled reduction of curative emphasis and provision of medications to the BHW should begin now.

-MSH-supported MOPH refresher training should continue, with increasing attention to training slanted to the non-curative elements of primary health care, with particular emphasis on MCH care.

-The Ministry and MSH should train now for maintenance of 1500-1700 BHWs, largely training for losses from attrition. At least 80 percent of future BHWs should be deployed to Area Health Schemes or to provinces where hierarchal health services are being established. Deployment of health assets of USAID PVO grantees should follow the same formula.

-MOPH and MSH should lobby for inclusion of greater amounts of preventive and promotive elements of PHC, including MCH care, in all training and orientation of mid-level health workers, and that as a condition of funding, USAID should insist that at least a working knowledge of the concepts of PHC should be emphasized in training courses provided by USAID-supported PVOs.

-Managerially it would make sense that O/AID/REP's backstopping of MSH and the PVOs (IMC, FM, MCI) engaged in these health activities be vested in the same technical backstopping officer.

-MOPH and MSH should further define the concept of the Rural Health Officer (RHO) with full communication and consultation with the donor and PVO communities. We found evidence of resistance to this new category. By whom and why?

-If the job description of the RHO is developed and agreed upon, USAID should consider funding this category only with the caveat that 15 of the 40 requested positions be earmarked for females.

C. Competency-Based Certification of Health Workers

The SOW question concerns the desirability and feasibility of standardization of health worker levels and competency-based certification of health workers trained for Afghanistan.

With most others, the Team believes it is timely to standardize levels of health care workers and provide competency based certification.

-MSH needs to play a role in facilitating the MOPH's participation in, and both MSH and MOPH need to work with CMC and WHO on, the restructuring of the minimal skills lists for health workers.

-The Review Team recommends a compromise solution to the question of who should coordinate the standardization of categories of health workers and certifying the results of competency-based tests: after agreeing to the standards, testing would result in two certificates being given, one from the Ministry and one from WHO.

D. Vertical Programs and EPI

The SOW question deals with the establishment of vertical (as opposed to integrated programs) of health care delivery.

The Team is concerned that the MOPH may now want to adopt an expensive national vertical program for immunization, even though MSH advises the MOPH its system eventually should have the required minimum of vertical elements of EPI, strongly supported by a PHC system operating through a clinic-based/outreach strategy.

-The Team recommends that MSH attempt to influence Afghan authorities away from conceptualizing a predominantly vertical EPI program.

-The Team recommends against MSH funding of vaccines for its EPI support activities until the matter of UNICEF's ability to provide them is settled. In the event UNICEF is not prepared to

Library

PROJECT REVIEW

AFGHANISTAN
HEALTH SECTOR SUPPORT PROJECT (HSSP)

(Project No. 306-0203)

Prepared for:

The Office of the AID Representative, Afghanistan

Prepared by:

Merrill M. Shutt, MD, MPH, Team Leader
University of North Dakota
John Snow, Inc.

Michael R. Jordan, MPH
ANE/TR/HPN
AID Washington

Douglas Palmer, MPH
O/AID/REP Afghanistan

Lou Zopf, RN
John Snow, Inc.

January 15 - February 9, 1990